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EVALUATION OF ETHICAL IMPLICATIONS OF SELECTED ALTERNATIVES FOR PAYING PHYSICIANS UNDER THE MEDICARE PROGRAM

Alexander Morgan Capron

Univeristy of Southern California

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CHAPTER 1

EXECUTIVE SUMMARY

This report argues that the effects of changes in Medicare reimbursement methods have to be evaluated in ethical as well as medical and economic terms. Ethical considerations are not mere side-constraints to the field of medicine, they are inherent in it, and medicine as we know it would not be possible without recognition of, and general adherence to, certain ethical considerations. Chapter 3 examines the importance of three ethical considerations in particular, described as "fidelity," "fairness," and "access." The first arises at the level of the physician-patient relationship; in the Hippocratic tradition, the actions of medical practitioners are supposed to promote the interests of patients in preference to those of other people, including the physician him or herself. The second and third operate at the societal level; because of the special importance of health care, a just society will endeavor to develop a system for its distribution that treats providers fairly and ensures all its members have access to an adequate level of health care without anyone having to bear excessive burdens in obtaining the care.

Chapter 4 classifies the alternative payment methods (described more fully in the Appendix) that could be adopted in place of the Customary-Prevailing-Reasonable (CPR) fee-for-service program now used to reimburse physicians for services to Medicare patients according to several major variables: (1) potential financial rewards to physicians, (2) degree of financial (casualty) risk to physicians, and (3) degree of outside supervision. It then arrays these variables along a matrix that relates them to the ethical considerations sketched in Chapter 3. The chapter then evaluates the three major types of payment alternatives. While noting the

unpredictable and subjective nature of such an evaluation, the author concludes that capitation payment methods appear most favorable from an ethical vantage point.

The chapter closes by pointing out that the major difference between the adverse effects on fidelity caused by the present third-party, fee-for-service system and the effects of proposed cost-containment measures that would increase physicians' financial risks and decreases their rewards is that the former are (1) familiar to physicians, patients and regulators, and (2) place the weight of society on the side of preserving fidelity and protecting patients' interests, while the latter are novel and place the interests of the patient in opposition to those of society (as embodied in the Medicare reimbursement system). Thus, the various changes in Medicare reimbursement being considered do not appear to involve inherent ethical problems; rather, the difficulties of developing new attitudes, expectations, and institutional and personal relationships that characterize any major change in ground rules should be anticipated and steps built into the system to monitor for ill-effects.

CHAPTER 2

INTRODUCTION

This report provides a framework for examining the probable ethical implications to be expected under alternative methods of paying for physicians' services. This evaluation is one of several being performed to enable the Congress to assess the likely impact of changing the method of Medicare reimbursement.

The central focus of the assessments being carried out by the Office of Technology Assessment (OTA) for this project appears to be on those effects of reimbursement alternatives that can be evaluated quantitatively such as effects on the quality and the efficiency of care, and on the level of expenditures (both from Medicare funds and the implications for other payers). Attention is also being paid to systems factors, such as the feasibility of implementing the various alternatives and their adaptability and flexibility over time.

This report suggests that it is necessary for policymakers to attend to other effects of changes in Medicare reimbursement, aspects that are sometimes referred to as "ethical." Although these effects have economic, quantitative and organizational aspects, they are more evaluative or descriptive, and depend heavily on the judgment of the persons performing the analysis. In the original OTA project description, they were encompassed within several expected criteria for evaluation, including "equity," "acceptability to beneficiaries," and "acceptability to providers."

This report categorizes the effects into three general groups: effects on the physician-patient relationship, effects on the fairness of the reimbursement system to providers, and effects on society's ethical obligation

to ensure equitable access. The first category encompasses issues of physicians' fidelity to, or conflict with, the interests of patients, and of trust between patient and physician (which may, in turn, effect the patient's willingness to seek and comply with treatment, and the efficacy of that treatment). Although the report does not provide precise estimates of these effects, it intends to emphasize the importance of attending to the ethical as well as the economic effects of public policies and to illustrate one means of doing so. At a time when major changes in the methods of financing health care (such as the Prospective Payment System adopted for Medicare in 1983) have rendered precise statements about current behavior and the economic effects of further changes even more than usually unreliable, it seems especially appropriate not to rest policymaking solely on expectations about their quantifiable effects but also to take account of noneconomic factors. If the particular reimbursement alternative that is eventually adopted risks producing unfortunate results from the vantage points described in this report, then it would be prudent to develop means of monitoring for such effects, so as to permit them to be ameliorated.

The consideration being given to changing reimbursement methods arises, of course, from efforts at the Federal level (which have their counterparts in state and private actions) to contain the rising costs of health care. This underlying motivation is not without significance, for several reasons, two of which are addressed in this report. First, in the context of the physician's fidelity to the patient's welfare, significant alterations seem likely to occur in the three-part relationship of physician, patient-citizen, and state as a result of cost-containment efforts in public programs like Medicare.

Second, in the context of access to health care, it is apparent that once the cost-containment reforms have eliminated the most wasteful practices from the health care system, further efforts at cost-containment will succeed only by reducing the "quality" of health care (according to some traditional measures) or by excluding some patients from receiving some treatments--as it is reported, patients over 55 years-old are not referred for hemodialysis in Great Britain (Aaron, Schwartz, 1984). The present efforts at cost-containment in the United States do not seem severe enough to provoke such a change at the moment, though this eventuality remains part of the public agenda for discussion.

The other reasons for attending to the cost-containment motivations behind the present Medicare proposal raise ethical issues that evoke a procedural response; although very important, they are not the subject of this report. They were addressed recently by Morreim (1985), who pointed out that because the cost-containment program is governmental, special concerns arise about the manner in which it is crafted and considered.

> [Q]uestions of basic public policy should, wherever possible, be resolved by society as a whole--questions, for example, about which people will be helped, which diseases will receive research priority, and what proportions will be given to acute care versus preventive medicine. . . .
>
> [B]oth the discussion and the results of cost control planning need to be open to scrutiny. Only if our economic, medical, and moral assumptions and reasoning are clearly laid out can they be assessed for their accuracy and acceptability--and only then are we likely to construct a plan that successfully conserves fiscal resources while serving patients well (Morreim, The MD, 1985, p.36).

In addition to these issues of governmental process, this report also does not focus on the issues that arise as physicians attempt to develop new clinical methods for improving care without increasing costs. Nonetheless, in its

discussion of standards and suggestions for frameworks, this report is never far away from concerns about the procedures through which necessary changes will be developed, articulated, scrutinized, promulgated, and--one hopes--reviewed and revised.

CHAPTER 3

MEANING OF THE CATEGORIES DRAWN FROM ETHICS

The Place of Ethics in Health Care

This report examines several potential "ethical" implications of changes in Medicare reimbursement. The effects selected are far from the only important consequences of changes in reimbursement methods; indeed, they do not exhaust the effects in the ethical sphere, much less the likely economic, medical or organizational consequences. They have not been selected arbitrarily, however. To explain their centrality to any examination of the ethics of the situation, it is necessary first to consider (in a very brief and summary fashion) the role of ethics both in the traditional practice of medicine and in the larger enterprise that today is called "the health care system."

Medical Ethics

Ethical principles and codes lie at the heart of the practice of medicine; thus, changes in Medicare's methods for reimbursing physicians--with their intended and unintended effects on medical practices--will probably engender important ethical issues for medicine and society. The centrality of ethical precepts to medicine has substantive and relational roots.

On substantive grounds, ethical strictures are necessary because of the subject matter of medicine--the human body and its functioning.

> These professionally imposed restrictions on deed and speech grow out of the recognition that illness is inherently degrading and dehumanizing, and that it exposes and threatens the sick person's body, soul, and intimate relationships (Kass, 1985, p. 222).

Western ethical traditions, which rest on respect for persons (as articulated in the basic Judeo-Christian texts and elaborated by secular philosophers such as Kant), value privacy, bodily integrity, and personal autonomy. Touchings of others are permitted only with their permission, and bodily intimacies are usually limited to members of one's own family.

Physicians (and today, other health care professionals) are an exception to this rule; to seek treatment is to give implied permission for many forms of examination and manipulation of one's body by someone who is otherwise a stranger, and to share with this person many private facts, both those the physician discovers through examination and those conveyed verbally by the patient (Parsons, 1951). Moreover, the procedures used by physicians can involve grave risks to patients' life or health. Were these powers to be misused--that is, were they to be employed by persons who did not adhere to standards of decency and dedication to the welfare of those they treated--they could cause suffering and death.

Thus, the medical profession has long emphasized the need for its members to keep information about their patients confidential; furthermore, the very precept of professionalism (that is, self-regulation by a group that adheres to standards of conduct and meets standards of knowledge and training) (Freidson, 1970), is itself ethical in nature because the sanctity of the human body can be interfered with--and personal well-being endangered--only when the actor is qualified as a member of the professional group, with the necessary skill and learning and with the appropriate dedication to the welfare of patients.

The sensitive content of medical care is closely connected to the second set of reasons that ethics is central to an understanding of medicine: the relationship between the physician and the patient. The nature of the

material over which the physician has control--at once very personal and very techologically sophisticated--creates an imbalance between physician and patient, with the former usually having much greater power than the latter, who will often be desperate for aid to relieve an acute and troublesome problem (Freidson, 1970). Furthermore, patients are typically less knowledgeable about their health care needs and the alternative means of meeting these needs than are physicians; indeed, patients are relatively more ignorant in choosing who, where, how (and often, when) health care will be supplied than they are about choices in most other spheres of their lives.

> The physician, not the patient, combines the components of care into a treatment. In other markets the consumer, with varying degrees of knowledge, selects the goods and services he desires from the available alternatives. In medical care, however, the patient does not usually make his choice directly.... He selects a physician who then makes...choices for him (Feldstein, 1966, p. 138).

Of course, the "doctor knows best" concept is no longer as forceful as it once was (Chapman, 1984), but despite "consumerism" and the legal requirements of "informed consent," physicians remain remarkably resistant to sharing information--much less authority--with their patients (Katz, 1984).

If patients viewed physicians in the same light as they do other people selling goods and services, the imbalance in power and authority could obviously have a very baneful effect on the physician-patient relationship. To overcome this, the medical profession has articulated certain duties of practitioners to patients, so as to reassure the latter that they are more than customers and need not fear being taken advantage of, as they might in ordinary commercial or industrial situations.1 Thus, ethical principles are not a mere adjunct to the practice of medicine but are its bedrock, for without these principles the relationship between patient and physician--which is built on trust and aims toward cure and relief of suffering--would not be possible.

Health Care Ethics

While medical ethics has a long history, in recent years philosophers have turned their attention to questions of right and wrong beyond the sphere of the individual physician-patient relationship, out of a recognition both that decisions made within this relationship can have profound consequences for society and that the actions of society (and its constituent parts, from the organs of government to small, voluntary groups) may determine who receives what medical attention (Freidson, 1970). Some of the concerns that have been identified in this sphere have come under the heading of "bioethics."2 Other concerns--those that will be discussed here--focus on the relationship of individuals to the larger society, and particularly on the obligations of society regarding its members' health and health care; this area is perhaps best described as "health care ethics."3

The ethical concerns that arise here are not unconnected with those traditionally associated with medicine, however. The very nature of medical care--which was previously described as the substantive ground that generates medical ethics--has a societal dimension. This dimension was slower to emerge than the individual aspects of ethics in medicine because it was only recently that medicine could provide dramatic benefits for patients. With the emergence of an impressive array of life-enhancing and life-prolonging medical techniques in the last half century, health care has taken on new significance; concurrently, as the expense of obtaining such treatments has risen dramatically, illnesses and injuries have come to pose potentially catastrophic economic as well as biologic risks for patients and their families. During this same period, the idea that governments exist in part to provide a means to relieve misfortune gained considerable (if not unanimous)

acceptance. Thus, the system of health care came to be seen as an appropriate field for the application of the basic ethical principles, about justice, liberty, and personal versus collective obligations. Indeed, the importance of health care to human well-being has made it one of the leading arenas for conducting contemporary debates about the nature and meaning of the ethical principles themselves.

The remainder of this chapter examines the content of three major categories of ethical consequences which can be anticipated to flow from changes in the methods used by the Medicare program to reimburse physicians. The first two are within the traditional concerns of medical ethics, and the third partakes of the social ethical concerns of health care ethics.

PHYSICIAN FIDELITY TO PATIENT INTERESTS

As has already been suggested, medicine is grounded on ethical premises and probably could not operate without the articulation of those premises or something very like them. At the heart of the physician-patient relationship, according to traditional ethical codes, is the primacy of the patient's interests above all others, including those of the physician. In the Hippocratic tradition this was expressed as primum non nocere ("first do no harm"), which was largely a reflection of the limited value of most then-existing medical interventions, rather than an affirmative limitation on the duties of the physician. The paternalism of the Hippocratic documents may seem outmoded to lay people today, but that very paternalism simply underlines the fact that the ethical code's central tenet was protection of the patient. Indeed, it is apparent that from early times physicians have recognized the need--for principled as well as practical reasons--to establish a professional standard of fidelity to individual patient's interests in order to be able to

raise their profession above the level of a trade or other commercial undertaking. Consequently, physicians are bound by ethical obligations toward those whom they treat not because the parties to an individual relationship have expressly articulated duties of fidelity and agreed to abide by these duties but because of the standard established by the interaction of the medical profession and society over time. As Beauchamp and Childress have observed, duties of fidelity may stem from the generation of expectations through words, gestures, or silence. Promises or contracts may be explicitly, implicity, or tacitly made. Such promises or contracts are binding for physicians, other health care professionals, and researchers, except when they are overridden by stronger duties or obligations (Beauchamp & Childress, 1983, p. 239).

Appropriate Care

Of course, there is no guarantee that physicians--or other health care personnel, or anyone else for that matter--are as perfect as their ideals. Thus, while it is the task of this report to examine the ethical implications of changes in Medicare reimbursement, it would be naive to begin with any assumption that physicians' behavior under existing reimbursement methods fully adheres to the principle of fidelity. Were that the case, the question would simply be, to what degree will deviations occur as a result of alternative reimbursement procedures? But such an assumption would be mistaken. The historical record makes clear that many steps have been taken by the medical profession which aimed to promote the interests of the profession, though they were not always necessarily hostile to the interests of patients (Starr, 1982). Indeed, even the organization of third-party payment mechanisms--and especially the limitations on the methods of payment

under such mechanisms--seem to have been directed toward enhancing the well-being and authority of the profession.

In light of the recognized risk that physicians may not behave ideally, how is one to know whether a particular physician is adhering to the commandment of fidelity to the interests of patients? Plainly, one cannot look to outcome alone, lest the physician whose patients' natural good health (or self-limiting illnesses) creates little need for the physician's ministrations would appear to be providing the best care, while the physician who attempted to save lives against great odds would falsely appear to be doing the greatest disservice. Nor is it possible--for reasons that have already been suggested--to leave the matter of judging fidelity solely to patients, who lack expertise and thus may be impressed by the "bedside manner" of a physician who is doing them no good or may reject the care of someone else who is actually employing the appropriate means.

Yet it is exactly on this point that the technical difficulties intrude. As has been shown for more than a decade (Wennberg, Gittlesohn, 1973), the practice of medicine is characterized by large differences in the rates at which various techniques are utilized. Rather than reflecting variations in individual competence or personal idiosyncracies, such differences typically vary by locality, even when adjustments are made to account for differences in the patient mix. Moreover, no marked variations have been found in the mortality rate or reported incidence of disease in the areas studied (Wennberg, 1984). Some of the differences in frequency are so great (up to eight or nine-fold) as to render of dubious value the notion of "standard, accepted practice," because it means that for some procedures it is apparently professionally acceptable to have four or five times as many surgical procedures of a particular type per capita as in a neighboring

community. Furthermore, as the authors of one recent study of this phenomenon pointed out--in the course of trying to estimate how much is wasted in their state because of unnecessary treatment--there is no reason to believe that even the lowest current rate is the appropriate rate, for physicians in all geographic areas in the state may be doing too much of the procedure (Barnes, O'Brien, Comstock, et al., 1985). Conversely, even the highest rate may be too low.

Thus, at the heart of the central ethical principle of fidelity to the interests of the patient is a large measure of individual judgment, which in turn partakes of a certain arbitrariness. Although the choices made are often lumped under the heading of "professional judgment," this term is misleading because it suggests that what is involved is a highly individualized application of generally accepted norms of practice, when in fact the profession has left large areas of "proper practice" largely undefined (Komaroff, 1983). Moreover, to the extent that more than personal judgment is involved, decisions may be guided by informal protocols that have grown up without careful examination or scientific basis.

> [A]d hoc routines develop and subsequently acquire authority and autonomous lives as informal protocols. Without any apparent critique or review, they are passed on from resident to resident and to medical student as a kind of folklore (Wong, Lincoln, 1983).

Outside of medical schools and teaching hospitals, such informal and unproven medical habits spread from colleague to colleague, probably accounting for the wide variations from one community to the next in the frequency of common procedures like cesarean section, hysterectomy, and tonsillectomy.

Of course, there are means--both within the profession and through the courts--to identify practitioners whose efforts are so far off from the best interests of their patients (though usually from lack of skill or attention

instead of conscious choice) as to be "negligent." But these means are cumbersome, and tend only to be invoked when a very bad result has occurred, which (as was pointed out previously) may be a very biased mode of selection in both directions (i.e., including some cases of bad outcome that are not due in the least to physician negligence and excluding others in which an outcome was, fortuitously, not as bad as was risked by the physicians' conduct).

Trust

Fidelity to the interests of the patient means more than simply providing care of acceptable quality, even assuming that--notwithstanding the problems just surveyed--the contours of "acceptable quality" were clearly discernible. Patients expect their physician to respect their moral limits, promote their welfare, and favorably balance the prospective benefit and harm in prescribing care (Beauchamp, Childress, 1983). In seeking medical care, a patient aims to select a physician in whom he or she can "have confidence."

> This may be interpreted to mean that the relationship is expected to be one of mutual "trust," of the belief that the physician is trying to help the patient and that conversely the patient is "cooperating" with him to the best of his ability (Parsons, 1951, p. 464).

The patient's trust derives, in part, from the special role and attendant duties which have been created for the physician.

> Certain roles, because they serve needs of such essential importance, have been granted extraordinary privilege and priority. The physician, perceived as preserver of life, has traditionally been a man of great privilege and has pledged himself to honor that privilege with

> responsibility. In order to sustain a relationship in which one individual places his very life in the hands of another, there must be some assurance that the relationship will be governed by its primary purpose: that is, the good of the patient, the preservation of his life, the protection of his well-being. The physician is under oath to "do no harm." It is the basis of trust on which the profession of medicine has survived.
>
> Any infringement on the inviolability of this contract threatens the whole medical structure (Gaylin, 1974).

One way the trust relationship has been described is as a covenant or contractual relationship.

> A traditional concept of the physician's role is that his relationship with the patient is an implied contractual one in which he uses his special expertise and competence as agent for the patient. Implicit in such a contract is that the physician can be trusted to treat the patient's health needs and interests as central, thus minimizing the need for the patient to be defensive or to withhold information. Both the status of the physician and the ethical bases of his practice facilitate the patient's willingness to put his health in the hands of the physician with little demand for detailed explanations or monitoring of the physician's decisions. This is not to imply that physicians have always conformed to these ethical mandates or that patients have generally been docile, but only that the physician's authority has been assumed to be part of the ordinary understanding of relationships between physicians and patients and their respective responsibilities. The structure of the contract has tended to increase not only the physician's technical authority, but also his "moral" influence (Mechanic, 1978).

The physician's legitimacy and authority are clearly undermined when he or she fails to honor this contract (e.g., failing to speak the truth; providing inadequate treatment because of cost constraints; overproviding treatment to increase income). Breach of this contract violates the patient's trust.

> An individual is morally bound to keep his promises because he has intentionally invoked a convention whose function it is to give grounds--moral grounds--for another to expect the promised performance. To renege is to abuse a confidence he was free to invite or not, and which he intentionally did invite. To abuse that confidence now is like (but only like) lying; the abuse of a shared social institution that is intended to invoke the bonds of trust. A liar and a promise-breaker each use another person. In both speech and promising there is an invitation to the other to trust, to make himself vulnerable; the liar and the promise-breaker then abuse that trust (Fried, 1981).

On the other hand, when physicians demonstrate their commitment to the trust relationship, the patient feels comfortable in seeking treatment from physicians. It has even been found that for many patients the resulting trust in the physician and his or her judgment actually increases the therapeutic benefits (Freidson, 1970).

The legal nature of this trust relationship was discussed in Canterbury v. Spence (1972, at 782). In articulating a physician's duty to disclose "material" information to a patient before seeking the latter's consent, the United States Court of Appeals for the District of Columbia declared:

> The patient's reliance upon the physician is a trust of the kind which traditionally has exacted obligations beyond those associated with arm's-length transactions. His dependence upon the physician for information affecting his well-being, in terms of contemplated treatment, is well-nigh abject. [L]ong before the instant litigation arose, courts had recognized that the physician had the responsibility of satisfying the vital informational needs of the patient. More recently, we ourselves have found "in the fiducial qualities of [the physician-patient] relationship the physician's duty to reveal to the patient that which in his best interests is important that he should know."

Fulfilling the interests of patients, as they themselves define them, is the criterion for successful medicine (provided of course that the interests sought by the patient come within the purview of medical practice). But patients' expectations of what medicine can do to promote their interests--and, indeed, the very definition of those interests--depend on

patients' trust relationship with their physicians.

Issues of patients' trust in the health care system--and not solely in their individual physician--may emerge as particularly important in the current cost-containment environment. And these issues take on a special twist in light of another aspect of "trust" in health care. As Robert Veatch has observed:

> "Trust" is an ambiguous word in medical ethics. It is touted as the moral basis of the patient-physician relationship, yet is also the foundation of the collegial relationship of one physician to another and of physicians to other members of the health care team. The Hippocratic oath is first of all an oath of secrecy and loyalty to one's medical colleagues (Veatch, 1977, p. 113).

To the extent that peer review of the adequacy and appropriateness of diagnosis and treatment plays a significant role in the success of a particular Medicare reimbursement system for physicians, the possibility arises for "trust" to assume its contradictory meanings: patients trust that they will learn (from the health care system) everything important about the care being received including the ways in which it may have been inadequate or inappropriate (especially where further interventions are called for), while physicians trust that their medical colleagues will not harm their relationships with patients by revealing their errors or professional inadequacies. This problem can arise in fee-for-service medicine and is not unique to new forms of reimbursement, but the growth of formal review mechanisms accompanying prospective and capitated systems is likely to increase not merely the recognition of instances of medically improper or inadequate care but also patients' understandable sense of being misled (at least by omission) if they do not learn of these inadequacies. Of course, patients might derive sufficient reassurance from the internal checks and automatic corrections of a system that operates well without having to convey

each case of "inadequate care" to the individual patient, except when remedial care is required to protect a patient's health and well-being.

FAIRNESS AMONG PHYSICIANS

Trust between physicians is only one dimension on which the reimbursement system's effects on providers can be evaluated. Another important--and perhaps more central--issue is the fairness of the rewards provided to different physicians for their professional services. Again, a theory that defined justice by reference to simple equality would ignore too many significant distinctions and would have perverse effects on physicians' behavior.

If one seeks equitable teatment of physicians in the reimbursement system, however, it is difficult to specify what formula should take the place of equality. It might seem that a reward for the complexity of interventions would be appropriate, but the implementation of this standard carries with it its own distortions toward complexity. Similarly, a formula that rested on the predicted value of an intervention to a patient's life would reward "heroics" in the face of death and leave little incentive for the provision of many interventions that are needed and desired by patients though their quantitizable value is relatively slight or, like much of medicine, has simply never been demonstrated by controlled studies.

An even more difficult issue is whether the correct frame of reference should be the procedure or the person who performs it. From a patient's viewpoint, at least in the short run, the primary concern is with the procedure and its outcome. If an operation can be performed to equally good effect by either of two physicians, any differences between them (in terms of skills, training, or other credentials) may seem irrelevant. A standard that

looks to the procedure and not the person would more closely resemble the usual market transaction, and hence (in the present terms of reference) achieves an air of ethical neutrality.

Nonetheless, from the system's viewpoint, the existence of certain highly skilled practitioners--who can operate at the frontiers of the field--is desirable. If an extra reward to them helps to encourage the extra investment of time and expenses necessary to achieve such an advanced level of proficiency and knowledge, it can be seen as desirable--in effect, by overpaying for a simple procedure (that could be performed equally well but for a lower fee by a nonspecialist), the system subsidizes specialists who are then "at the ready" for the less frequent occasions when their special skills are needed.

From an ethical viewpoint such an arrangement can be viewed as unobjectionable--since the nonspecialist may well admit that his or her time is "less valuable" than that of the specialist or subspecialist. Yet the extra financial reward on balance seems unjustified since (a) the reimbursement system is supposedly geared to what is done for patients (i.e., the value of the procedures), and (b) to the extent that reimbursement should be geared to the costs of inputs (including the costs of extra training, etc.), the specialist who does a procedure that can be done for a much lower price by a less highly trained individual is <u>choosing</u> to follow a nonefficient use of his or her own resources, a choice the system ought not to encourage. The only counter to this (the "at the ready" argument) is very imprecise and is likely to result in over-encouraging specialization.

PATIENTS' ACCESS TO HEALTH CARE

The final set of concerns centers on the distribution of health care in

society, and particularly the ethical issues that arise when certain people or groups lack access to health care.

Patterns of Access to Care

Despite an enormous expenditure of public and private funds, the American health care "system" does not encompass all Americans. These problems with access are not limited to residents of rural or inner-city communities, nor to the very poor, but extend to families with modest incomes, particularly when the family's wage-earners work in seasonal or low-paying jobs or become unemployed. People in these circumstances are often not covered by any form of private or public health insurance; consequently, in comparison to people who are insured, they are less likely to seek care promptly when sick and are more likely to face substantial obstacles in obtaining adequate care, particularly for chronic or other nonemergency conditions (Davis and Rowland, 1983).

A 1983 report by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research found that at any one time 22 to 25 million Americans lack health insurance, which amounts to 11-12.6% of the noninsitutionalized population (President's Commission, Securing, 1983). Over the course of the year, an even larger number--about 16%--are without insurance at some point, because some people lose their coverage due to change in employment status or change in income (which determines eligibility for some public programs). Needless to say, the absence of health insurance is not evenly distributed across income groups; among those families of four with incomes below $10,000 in 1977, 27% lacked health insurance for all or part of the year, while among like families with income over $32,000, 90% were insured, and those who were uninsured would

plainly be more able to meet more health care bills from their own funds (Wilensky & Walden, 1981). Indeed, in 1977 poorer members of the population not only spent a larger proportion of their income for out-of-pocket health care expenses than higher income people, but also spent more in actual dollars per capita (President's Commission, Securing 1983)--an ironic situation that may have altered somewhat as private insurance programs have markedly raised their co-payment requirements in the past several years (Crozier, 1984).

Is it significant that when individuals lack insurance they use substantially fewer health services, even though they are no less in need of care (Wilensky & Berk, 1982)? Even without adopting a nihilistic view of the value of medicine in general, there are good reasons to doubt the efficacy of a great many medical procedures in many of the situations in which they are used. Indeed, there are no methods agreed upon and in general use to evaluate the cost effectiveness of medical techniques and practices. Consequently, a lack of access to care might seem insignificant. Yet, despite the skepticism thus generated, the results of having access to adequate health care can be dramatic, as suggested by the notable increases in longevity and reductions in morbidity that have come with the advances in health care capabilities in this century. More particularly, recent reports demonstrate that utilization of medical care leads to a marked reduction in mortality rates (Hadley, 1982; Grossman & Goldman, 1981).

Of course, it would be a mistake to equate the levels of hospital and physician services used by insured, white middle-class patients with the optimum level; thus, the fact that insured whites under age 65, in fair to poor health, averaged 7.2 physician visits per year does not prove that uninsured whites in similar health (who saw physicians only 4.5 times per year) or uninsured nonwhites (who averaged only 2.6 visits per year), were

necessarily receiving too little medical attention (President's Commission, Securing, 1983). Yet such a conclusion can be drawn--and the adverse effects of lack of access to health care can be seen--from other facts, such as the clinically significant worsening of health status observed in medically indigent patients who have lost Medicaid coverage because of changes in eligibility rules. For example, one study of such patients in California in 1983 found that six months after termination of benefits, patients with hypertension had experienced a 10 mm hg rise in diastolic blood pressure (which increases their relative risk of dying by 40 percent). The study associated this result with the unavailability of care for this indigent population.

> Fewer medically indigent adults could identify a usual source of care (50 percent after termination vs. 96 percent before termination), fewer thought that they could obtain care when needed (38 percent vs. 83 percent), and fewer were satisfied with their care (60 percent vs. 91 percent) (Lurie et al, 1984, p. 484).

Ethical Implications of Lack of Access

As the President's Commission concluded, the disparities that exist today in Americans' access to health care take many forms:

> variations in level of financial protection against health care costs, in the financial impact of health care expenses, in the use of services, in the availability of health resources, and in the use of different settings offering varing levels of quality of care (President's Commission, Securing, 1983, p. 108).

Again, variations are not necessarily proof that those receiving a lesser amount of care are being mistreated ethically any more than that they are being undertreated medically. Yet when it is recognized that inability to pay for care is an important determinant of entry into the health care system and of use of medical services, it is apparent that the problems that flow from a lack

of insurance and resources can include inadequate health care being obtained and excessive burdens being imposed for such care as is obtained.

Thus, the issue becomes: in what sense are inadequate health care and excessive burdens in obtaining care ethical problems? In American society many goods and services are distributed unevenly without raising serious concerns that an injustice is being done. Why should health care be regarded differently? And what are the implications for society of treating health care differently--for example, does it then follow that access to health care is a right, to which all Americans are equally entitled?

Why is Health Care Special?

Many goods and services are important to personal satisfaction and well-being, but there are good reasons for singling out health care as being particularly subject to the dictates of justice. Good health itself is what philosophers term a "primary good," since one need not know another's peculiar preferences and goals to know that the person will value health, which is necessary for fulfilling those preferences and goals. Although people do not all assign the same weight to health (or even life), the connection between health care and the opportunity to enjoy life and pursue one's other objectives is self-evident; a prime objective of such care is to restore normal functioning or allow a person to function more nearly normally by overcoming the effects of disabilities or defects.

Other factors (like food and housing) are also necessary for health, but (especially in the care of acute illness) the connection between health and health care is more immediate: the prevention of disability and loss of life, as well as the relief of pain and suffering, frequently require that the person be able to obtain health care. Moreover, unlike other "necessities" of life,

the need for health care varies widely among individuals and over time for each person. Though most people can anticipate their needs for food, housing, clothing, and the like, and can budget accordingly, situations can easily arise in which all but the most wealthy would be unable to pay for needed medical services.

Of course, a large proportion of health services are not necessary to save life or even to relieve suffering and restore functioning. Physicians and other health care personnel spend a good deal of time dealing with the "worried well" and with patients whose medical problems are naturally self-limiting. This does not mean that these services are "wasted," nor does it detract from regarding health care as special from an ethical perspective. First, health care in these circumstances can relieve patients' worries and allow them to anticipate the future course of their condition and, as necessary, to adjust to it. Furthermore, by supplying reliable information, a physician or other health care professional can help a patient to avoid a fruitless (and possibly painful and expensive) search for further diagnostic or therapeutic procedures. Finally, health care has symbolic significance: a person who receives it will probably feel cared for, a person deprived of it--in a society where it is generally available under like circumstances--will probably feel excluded from the human community. Thus, "health care has a special interpersonal significance: it expresses and nurtures bonds of empathy and compassion" (President's Commission, Securing, 1983).

Just Access

In light of health care's special status in ethical terms, what implications follow from the uneven access across economic and racial groups described above? By what criteria should the fairness of the distribution of

care be judged? Three criteria have been suggested and need to be considered: equality, need and equity.

Equal Allocation. Although justice is often served by treating people equally, the application of this standard to health care could have very odd results. It could mean that each person would be entitled to an equal amount of care over the course of a year or perhaps over the person's lifetime. Yet the need for care varies widely. If the amount of care guaranteed were set high to ensure adequate care for those with chronically poor health status, an enormous drain would be imposed on resources that could be used to meet other, non-health care needs; conversely, if the level were set much lower to meet the needs of people in average health or better, services that could preserve life or restore health would be unavailable for some sick people.

Even if equality is interpreted to mean equal amounts to persons with equal needs, the standard still faces serious problems, for two reasons. First, even when people's needs are the same, their desire for care may vary, reflecting the relative weight they place on the burdens imposed by the process of care and the value they assign to particular outcomes. Second, existing inequalities of wealth and income will produce different levels of use among people with the same objective "needs." Were resources of a certain type too limited to be made available to everyone, strict application of the equality standard would lead to such services being withheld from patients who wished to use their own funds to purchase health care rather than other goods and services. Thus, since "equality" does not provide a useful standard, the fact that health care expenditures are not even among individuals or groups in the population is insufficient ground for concluding that the distribution of care is unjust.

Distribution by Benefit. Alternatively, to overcome the nonsensical aspects of equal distribution when patients have unequal needs, justice could be interpreted to mean that everyone should have access to health care that will be beneficial to them. Yet, since there is virtually no end to the funds that could be used to achieve some possible medical benefit, using benefit as the basis of an ethical theory of health care distribution would open the door to unlimited spending on this one good, to the potential exclusion of many other individual and social goods. Health care is of special importance, but not sole importance. A just health care system can weigh the benefits of care against the costs of achieving those benefits in comparison with the other goods and services on which the resources are spent.

Equitable Access. Since neither "everything beneficial" nor "everything that anyone else is getting" is a defensible basis for judging the fairness of health care distribution, it has been argued that the correct standard is ensuring everyone equitable access to care, defined as access to "an adequate level of health care." The President's Commission concluded that equitable access to care requires that people not face "excessive burdens" in obtaining care--such as through out-of-pocket expenses, travel and waiting times, and the like (President's Commission, Securing, 1983).

The adequacy of care has to be evaluated in the context of a particular society at a particular time; the availability of resources could make a level of care that would be inadequate in one society adequate in other. Likewise, the expectations of members of a society about the types of care that will be provided in various circumstances helps to define adequacy because the definition refers back to the factors that made health care special. Adequate care is

> enough care to achieve sufficient welfare, opportunity, information, and evidence of interpersonal concern to facilitate a reasonably full and satisfying life. (President's Commission, Securing, 1983, p.20)

Rather than being open-ended, the obligation created by the adequate care standard recognizes that society's resources are limited and have to be made available for other uses that are judged more important than meeting certain health care needs.

This view of equity in health care has two major implications for the present topic. First, it views health care as a whole: as a complex system in which physicians and other professionals, institutions, and individual patients are not the only actors but participate with others, such as employers, insurance companies, and the local, state and Federal governments, each having obligations as well as rights vis-a-vis the others. Thus, actions taken by the Federal government to change the methods used to reimburse physicians, for example, cannot be judged solely by their effects on /sicians or the Federal treasury but must as a matter of ethics be rutinized for their effects on how well the system is fulfilling society's)ligation to ensure that each person has access to an adequate level of ealth care.4

Access to Care vs. Other Ethical Goals

Ethical theories are intended to provide means for examining and perhaps resolving value conflicts. As the discussion thus far has shown, such conflicts are not always ones of the variety of good (e.g., better health) vs. evil (e.g., decreased access to needed health care); rather, they are often matters of one good (increased access to health services) versus another (better schools, safer neighborhoods, more knowledge through research). Although many physicians--and others--resist the notion that value conflicts

involving the use of resources should ever be resolved at the bedside, it is now generally acknowledged that they do have to be addressed at the "macro" level and that to do so one may have to move beyond health care ethics to encompass general social ethics in the distribution of resources in society.

Because of the good-vs-good nature of some of the choices being made about health policy, it will not be enough for macro-ethical analysis to focus on the impact on access of changes in reimbursement methods. This is an important dimension, but ethical analysis must also take account of other effects of the changes in reimbursement, especially reductions in the total amount of Medicare spending below that which would have occured in the absence of the policy changes. If such reductions preserve other important features of the program (that might otherwise be dismanteled) or make available funds which are then put to other important uses, the allocative decisions have to be judged on their own merits. A rigorous ethical analysis will insist, however, that decisions which limit the amount of benefical care received be disapproved if Medicare could have saved a like amount by expending its funds more efficiently (i.e., that decisions reflect what is known about cost-effective medical care).

This concern is not merely technical but rather is ethical as well. Changes in the health care system (such as in Medicare reimbursement policies) should be regarded as ethically desirable to the extent that they increase the access of people to appropriate health care and, contrarily, as undesirable to the extent that they fail to do so. This necessitates assessment of two points: (1) we must ask not merely "will this program save money for the Federal government?" but also "as a result of this program, will the change in access to care increase (or at least not decrease) the number of people with reasonably full and satisfying lives?" And (2) we must establish means for

measuring the effects of the program to see whether the situation is actually improved. If the effect of a change in reimbursement were to make Medicare participants so unattractive as patients that some of them lost the ability to obtain adequate care this would plainly count heavily against such changes on fairness grounds; conversely, if a change in reimbursement methods for Medicare either freed up monies for the treatment of other patients in public programs who now lack access to care, or otherwise encouraged or induced physicians to care for more such patients, it would count as an ethically beneficial result in evaluating the program.

Economists are fond of saying that what is involved is the rationing of scarce resources; to those who object that we should not ration health care, they reply that we already do so (Fuchs, 1984). Unlike age-related standards of the type found in Great Britain, our rationing has tended to be based on income and wealth (Aaron & Schwartz, 1984). There are important ways in which this less formal means of allocating resources differs, however, from explicit decisions to deny a group of people a service that is necessary for their life or health (which is the stronger sense of the term "rationing"). A process that merely allocates resources while not categorically denying needed care permits society to maintain its allegiance to other important values, such as the sanctity of life and the equal worth of all persons (Calabresi & Bobbitt, 1978). The benefits in social and ethical terms from such an approach sometimes recommend it; its acceptance usually depends upon a perception of procedural fairness in the allocative processes, in order to overcome the fear that might otherwise arise that the informality or invisibility of the decisionmaking process provided a cloak for biased choices by the decisionmakers.

FOOTNOTES

1. The 1847 Code of Medical Ethics of the American Medical Association stated, in part:

CHAPTER I OF THE DUTIES OF PHYSICIANS TO THEIR PATIENTS, AND OF THE OBLIGATIONS OF PATIENTS TO THEIR PHYSICIANS

ART. I. Duties of Physicians to their Patients

1. A physician should not only be ever ready to obey the calls of the sick, but his mind ought also to be imbued with the greatness of his mission, and of the responsibility he habitually incurs in its discharge. Those obligations are the more deep and enduring, because there is no tribunal other than his own conscience, to adjudge penalties for carelessness or neglect. Physicians should, therefore, minister to the sick with due impressions of the importance of their office; reflecting that the ease, the health, and the lives of those committed to their charge, depend on their skill, attention and fidelity. They should study, also, in their deportment, so to unite tenderness with firmness, and condescension with authority, as to inspire the minds of their patients with gratitude, respect and confidence.

2. Every case committed to the charge of a physician should be treated with attention, steadiness and humanity. Reasonable indulgence should be granted to the mental imbecility and caprices of the sick. Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; and the familiar and confidential intercourse to which

physicians are admitted in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honor....

3. Frequent visits to the sick are in general requisite, since they enable the physician to arrive at a more perfect knowledge of the disease,--to meet promptly every change which may occur, and also tend to preserve the confidence of the patient. But unnecessary visits are to be avoided, as they give useless anxiety to the patient, tend to diminish the authority of the physician, and render him liable to be suspected of interested motives....

5. A physician ought not to abandon a patient because the case is deemed incurable; for his attendance may continue to be highly useful to the patient, and comforting to the relatives around him, even to the last period of a fatal malady, by alleviating pain and other symptoms, and by soothing mental anquish. To decline attendance, under such circumstances, would be sacrificing to fanciful delicacy and mistaken liberality, that moral duty, which is independent of, and far superior to all pecuniary consideration....

CHAPTER III. OF THE DUTIES OF THE PROFESSION TO THE PUBLIC, AND OF THE OBLIGATIONS OF THE PUBLIC TO THE PROFESSION. There is no profession, by the members of which, eleemosynary services are more liberally dispensed, then the medical; but justice requires that some limits should be placed to the performance of such good offices. Poverty, professional brotherhood, and There is no profession, by the members of which, eleemosynary services certain public duties referred to in section 1 of this chapter, should always be recognised as presenting valid claims for gratuitous services; but neither institutions endowed by the public or by

rich individuals, societies for mutual benefit, for the insurance of lives or for analogous purposes, nor any profession or occupation, can be admitted to possess such privilege.

In contrast to the detailed statement of 1847, by 1984 the AMA's Principles of Medical Ethics read in their entirety:

PREAMBLE:

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

2. See Fox (1979). Bioethics has addressed issues such as: when does death occur? what authority should patients, or others, have to decline life-sustaining treatment? what are the aims and limits of medicine? when, and for what reasons, is it acceptable to use genetic engineering for the treatment of human diseases?

3. This is not to suggest that the term "health care ethics" is always used in this fashion; for example, two priests, Benedict M. Ashley and Kevin D. O'Rourke, published a book in 1978 entitled Health Care Ethics: A Theological Analysis which is devoted to the issues identified here as matters of traditional medical ethics (e.g., the obligations of physicians, the role of ministers as pastoral counselors in medical decisionmaking, etc.) and bioethics (e.g. human experimentation, reproductive technologies, genetic engineering, definition of death, etc.).

4. It is important to remember that an ethical not a legal obligation is at issue here. To find that a society has an ethical obligation to do something is to conclude that its failure to do so is wrong and opens it to serious criticism. It does not mean that the persons who would be benefitted by society's actions have a corresponding right to demand society's aid. The courts have not held health care to be a constitutionally guaranteed right; thus, any discussion of "rights" in this context should be limited to the protection of those claims that individuals may have <u>within</u> the context of existing legislation (<u>i.e.</u>, that under existing law a Medicare beneficiary is entitled to have a certain payment made on his or her behalf), which does not answer the question of what future legislation <u>ought</u> to provide.

CHAPTER 4

ETHICAL EVALUATION OF ALTERNATIVE METHODS FOR MEDICARE PAYMENT

To analyze the ethical effects of the possible alternative methods for reimbursing physicians for treating Medicare patients, this chapter first identifies three major variable by which the reimbursement alternatives may be compared. It then looks at the impact of each of these variables on the three values described in Chapter 3: fidelity to patients' interests, fairness among physicians, and access to health care. Finally, it applies the preceeding analysis to produce brief evaluations of the three major variations in payments, and concludes with some general observations about the ethical difficulties that attach in a period of rapidly changing practices and expectations.

CLASSIFICATION OF ALTERNATIVES

Although the alternatives for reimbursing physicians vary in many ways, they can be usefully analyzed by examining three variables. First, to what extent does the plan reward physicians financially? Implicit here is some notion of the present system of CPR fee-for-service reimbursement as the baseline. Second, to what degree will the risk of financial losses be brought to bear on physicians' decisions, either directly or indirectly? This factor comes into play under prospective or capitated reimbursement programs, in which the health care provider functions in effect as an insurer of the patient's health. And third, what degree of outside supervision is built into the program, to monitor for quality of care and appropriate utilization of resources? In the past twenty years, the traditional independence of medical practitioners has been increasingly confined by the review processes of

hospitals and third-party payers; although physicians may chafe under this regime, if properly conducted it may serve their interests by reassuring patients that the care they receive is professionally acceptable.

Physician's Financial Rewards

The primary motivation for seeking new methods of reimbursing physicians for treating Medicare patients is to gain control over expenditures in this large governmental program, that is, both to achieve predictability and to restrain the rise in expenditures. Consequently, a characteristic common to all the proposals is some expected reduction in the amount a physician would otherwise receive for the care of the average patient. It is, however, necessary to distinguish those restraints on expenditures that reduce the price of individual units of care (i.e., examinations, diagnostic tests, surgical operations, etc.) from those that aim to reduce the number of units employed. The former operate, in effect, to reduce some of the monopoly rent that physicians are now able to extract for their services because of the structure of the market for medical care. The latter aim largely to limit the total cost of caring for a patient, by placing some of the costs of over-utilization of resources on the physician. (Other changes in Medicare not discussed here, have been instituted and further ones have been proposed to reduce usage by placing more of the costs of care on program beneficiaries.) A further complication is added by programs that have some form of mandatory assignment of Medicare bills, the effect of which is to prevent physicians from recouping from patients the amount lost on account of the program's limitation in fees.

Reducing Prices

A physician's charges for treatment of a patient reflect several factors,

principally returns on investment in equipment and other property, rewards for managing workers in the physician's employ, and rewards for his or her own work (which includes the physician's investment in education and specialized training). The present CPR fee-for-service system has given physicians a great deal of leeway, collectively and individually, to set the prices on these items because the market does not operate very effectively in this area. To alleviate this problem, one can turn to regulation (e.g. the proposals for modifying the fee-for-service system and for a fee schedule) or find ways to create more of a market, with "bidding" and other price-competitive behaviors (e.g. PPOs). The intended effect of such moves is to reduce the excess profits that providers can now extract; if the reforms worked, physicians would receive a reasonable reward as entrepreneurs (e.g., return on their investments in equipment and so forth, payments as employers of nurses and assistants, and reward for the risks of running a business), as well as payment for their own labors commensurate with what similarly educated people receive in the labor marketplace for similar exertions. The monopoly profit, however, would be removed from the price they could charge for a unit of service. Of course, if physicians have a particular income target in mind (including projected year-to-year growth) (Newhouse, 1970; Kronenfeld, Whicker, 1984) reducing the price of units of service may merely cause an increase in the number of units provided. Plainly, such an increase has different connotations if it results from physicians' providing service to a larger number of patients (Feldstein, 1981; Evans, 1974), than if it results from physicians' providing the same patients with more services, for the same diseases, while merely yielding the same health outcomes.

Reducing Numbers

The alternative strategy for reducing Medicare expenditures would be

through discouraging the use of unnecessary services by removing the current incentives to provide more and more units of input; this might be achieved through capitated payments (e.g., an HMO) or prospective payment per admission. Under arrangements of the latter type, however, physicians could still attempt to "game" the system; that is, faced with a total price per "package," it no longer makes economic sense to increase the number of units of service in the package, but economic returns could be increased if patients' needs can be "repackaged" (i.e., treatment of a condition divided into two parts, to become two treatments for two illnesses over two periods of time).

Assignment

Another variable that affects physicians' financial rewards is whether the program requires physicians to accept "assignment," that is, their agreeing to accept Medicare reimbursement in full payment of the bill. Such an arrangement is much more inherent in some of the proposals than others; indeed, in the case of capitation programs, one would not speak of "non-assignment" but of some form of co-payment by the Medicare participant (who would, in effect, be asked to pay a certain amount when services were rendered, beyond that automatically encompassed in Medicare's advance, per capita payment on the participant's behalf). Assignment rules can range in stringency from requiring that all the charges submitted at a particular time for a particular patient be paid exclusively by Medicare, to requiring that if the physician is going to bill Medicare for any treatment to any patient, the physician must agree to be limited to Medicare's reimbursement for all treatment to all Medicare patients.

Physicians' Financial Risks

An alternative way of viewing the relevant characteristics of the alternative reimbursement methods is to focus on their effects on physicians' exposure to financial risk as a result of their treatment decisions. At issue here is something akin to a casualty risk on which an insurance company might write a policy, rather than the financial risk that entrepreneurs face if they (or the market) have priced their goods and services so low that they are losing money with every transaction.

Because of the insurance-risk aspect of these reimbursement methods (such as prepaid coverage), health care providers typically "reinsure" against certain losses (e.g., an HMO that insures the potential hospital expenses of its enrollees with a commercial or nonprofit hospital insurance company, such as Blue Cross). Moreover, since the risks are greatly increased when the enrolled base is small, programs that entail high exposure (i.e., capitation, in which a provider is responsible for costs of all possible physicians' services for a group of patients for a period of time) would be considerably less attractive to individual physicians or small group practices than would programs that involve a lower "down-side" risk (e.g., DRG-based payments, in which the expenses of treatment would be limited to those incurred in a particular illness).

Financial risk can influence physician decision making through several routes. If the physician is directly responsible for providing care or paying for it (when other physicians are called into the case, as consultants, etc.), the restraining influence is a direct one. More likely are situations in which the influences would be indirect, in the form either of financial incentives/disincentives or of restrictions on physicians' decisions. The

first could arise in a variety of ways; a physician with an ownership interest in a group practice will be interested in avoiding extravagant treatment choices (and in encouraging colleagues to do likewise), as would a physician who has a joint-venture with a hospital or a "bonus" arrangement at an HMO, in which the surplus from "cost-effective" care is distributed (Ellwood, 1984; Capron, Gray, 1984). The second category of indirect influence has already appeared in the past few years as programs have been enacted to control hospital costs. In response to cost-cutting measures, the hospital has found that it can

> monitor physicians' spending patterns over time and, where high-spending physicians refuse to curtail their ordering habits, revoke their privileges to practice at that hospital. It can identify its most expensive products, services, and technologies, and place restrictions on their use. Physicians, for instance, might be required to apply to a utilization committee for specific approval each time they wish to order an expensive test. Or where a physician is judged to overuse a particular technology, the hospital might monitor or restrict his privilege to use that particular technology (Morreim, 1985).

In the context of trying to influence physicians to help control institutional expenses, some of these strategies may seem ineffective or even legally questionable (e.g., withdrawal of staff privileges). But in the context of changing the methods of reimbursing for physicians' services, as dealt with in this report, there may be more scope for such influences to work, especially vis-a-vis physician-employees (in hospital-based programs, HMOs, and the like).

Outside Review of Treatment Decisions

A third set of variations among the reimbursement alternatives is the extent to which they involve review of physicians' decisions by third-parties (i.e., HCFA or its agents). This supervision could differ from that just

mentioned, which is provided by someone (e.g., an HMO) at financial risk for the decisions made by the physician. It is very important to recognize, however, that depending upon the purpose of the third-party's review, such review might in fact be equivalent to that of the at-risk party. Indeed, the existing tradition of review of claims is quite similar in its objectives to the utilization-review processes used by hospitals, namely to identify unwarranted interventions and the physicians who chronically perform them.

Such a purpose, which looks to the conservation of resources (those of the individual institution and/or those of the third-party payer), must be distinguished from review that aims to advance the interests of patients. These objectives need not conflict; sometimes it is in the interest of a patient to be subjected to fewer interventions--from tests to surgical operations. But that is not always the case; were it otherwise, most of the justified sense of ethical risk arising from current efforts to contain costs would not exist.

Many forms of review already exist to police physicians' fidelity to patients' interests (as well as the maintenance of high quality care, which the previous chapter suggested is a related albeit not identical value). They include patients' own screening of physicians and willingness to "take their business elsewhere" if they find the physician uninterested or incompetent; malpractice suits (and the threat thereof); and various professional activities to screen out incompetent or dishonest practitioners. These methods give patients a good deal of protection, but they certainly have not eliminated the problems of inappropriate (and sometimes risky) care and health planners will need seriously to consider the degree to which existing methods should be supplemented as the financial incentives shift from too-much to too-little. Those new methods for physician reimbursement in which greater

oversight is inherent (i.e., those embedded in an institutional context rather than paying independent physicians) offer a readier means for internalization of a review process attuned to fidelity/quality concerns, but they also carry the risk that the institution's major concern will be with utilization-oriented review. In either case, additional attention to the fidelity/quality issues by HCFA will be needed; one means of evaluating the likely success of such efforts would be to evaluate experience with attempts to add these considerations to the review process in the wake of the adoption of prospective payment for hospitals in 1983 (Lohr, Brook et al., 1985). As HCFA in effect admitted at the time that the prospective payment regulations were first published, its then existing orientation and experience did not include methods for systematically monitoring the ill-effects incentives to undertreat Medicare patients (48 Fed. Reg. 39160).

CONSEQUENCES FOR ETHICAL VALUES

Effects on Fidelity to Patients' Interests From Limitations on Physicians' Financial Rewards

There was a time, well within the memory of many physicians still practicing today, when physicians were expected to--and did--provide a good deal of care without charge to patients with limited financial means, both in physicians' offices and at charitable, public and teaching hospitals. It might thus seem that merely limiting the amount paid to a physician for services to a Medicare patient would not affect the physician-patient relationship adversely because some payment, rather than free services, would still be involved. The remarkable growth in third-party coverage of health care costs in the past quarter-century, however, has changed practices and attitudes so markedly--and raised both the complexity and expense of medical

practices, and practitioners' expectations of earnings--that patients whose third-party reimbursement rates are "substandard" have a hard time commanding the attention, much less the loyalty, of many physicians.

Thus, the more effective a program (like a fee schedule) is in containing charges for physicians' services to Medicare patients, the less likely those patients will be to have their interests vigorously pursued. Obviously, there are mitigating factors. A program whose terms are set by the marketplace (such as a PPO plan) may not have as adverse effects, provided that it just "clears the market"--that is, the prices set permit physicians a fair return on both capital and labor, leaving the supply of physicians willing to provide acceptable, dedicated medical care in equilibrium with the demand for their services. Further, some programs, such as HMOs, offer administrative or other advantages to compensate for their lower rates of reimbursement. Even when a program does not provide such off-setting benefits, Medicare patients with long-standing relations with a particular physician or group will probably continue to receive appropriate attention (which suggests that, from an ethical viewpoint, patients who believe they have such relationships should have a program that permits them to retain it).

But the specter of two-tier (or multi-tier) care is an undeniable consequence of limiting Medicare reimbursement rates, particularly when collecting additional funds directly from the patient is precluded by strict assignment rules. One has only to look at the type of medical care received by residents in most nursing homes in this country (Vladeck, 1980) to recognize that a low level of payment can produce a low level of fidelity to the interests of the patient.

In some ways, it may seem ironic that limitations in the level of payment--particularly those, such as capitation programs or expenditure-caps in fee-for-service situations, that remove financial incentives for unlimited tests and procedures--could be thought to cut against physicians' fidelity to patients interests. After all, the risk that physicians will overtreat their patients to serve their own economic interests lay at the heart of traditional ethical examinations of the physician-patient relationship, even before the advent of third-party payment.

Health insurance is often taken to be the cause of overtreatment because it not only insulates patients from many of the financial consequences of their medical care choices (and thus distorts their attitude about the relative benefit of medical interventions) but also leads physicians to think that, since no economic interest of their patients will be harmed, they should always do more, not less. This leads to "unnecessary treatment, [and] uncritical use of costly adjuncts such as hospitalization in lieu of (often preferable) ambulatory care, and an intricate battery of excess laboratory studies" (Chapman, 1984, p. 146). Yet even before the existence of third-party payments, the physician's financial stake in doing more rather than less served to put his or her interests in conflict with those of the patient.

Because of this potential conflict of interest medical ethics cautioned physicians to put their patients' interests first and to restrain their impulses to intervene. That did not eliminate the conflict, but at least the conflict was openly acknowledged and the ethical expectations of the profession were made clear. As the conflicts became more acute but less visible, with the growth of investor-owned health facilties in which physicians are among the investors, the ethical norms need to be reiterated and strengthened if patient interests are to be protected (Relman, 1985).

From Physicians' Increased Exposure to Financial Risks

Reversing the financial incentives--to make it disadvantageous for physicians to treat more intensively--poses the conflict-of-interest issue in a somewhat unfamiliar way. This unfamiliarity--on the part of physicians as well as patients--is itself part of the problem. Until recently, the relatively small proportion of patients and physicians in arrangements such as HMOs were people who self-selected for this reverse-incentive situation, against the background of a predominantly fee-for-service system. An ethos grew up for these programs that established mutual expectations and provided the necessary insulation of physicians from undue conflicts with the interests of their patients. If anything, physicians in such settings had to go out of their way to demonstrate that their decisions about patient-care were never influenced by the financial risk to their organization created if they were "too successful" in maintaining a patient.

This points to the fundamental difference in evaluating the ethics of the current proposals: in the past, the weight of the societal expectations reinforced the physician's presumption in favor of offering (and sometimes imposing) anything that the physician believed might be of value to the patient, but the reimbursement plans that place physicians and medical institutions at financial risk are intended as a means of allying physicians to society's new position that many medical interventions are not cost-beneficial and ought to be avoided. At the very least, the cost-containment efforts presume that it is possible to reduce health care expenditures without making patients worse off; some would go further and say that either now or in the near future it will be necessary routinely to withhold (or at least decline to pay for) some interventions that might benefit patients but that

simply cost too much for society to justify the marginal expenditure. In either case, the collective attitude would no longer be a check on any temptation of physicians to serve their own interests at the expense of their patients'interests; instead, society would be attempting to use physicians' inclination to serve their own interests in order to restrain full pursuit of patients' interests.

Of course, life is not such a simple cartoon as this picture might suggest: physicians' norms are deeply ingrained; society does not speak with one voice, and the voice of Medicare officials is not likely, in any event, actually to proclaim the value of slighting patients' interests; and finally, there are many who believe that it is at least a close question whether patients would not be much better served by being treated much less aggressively and subjected to many fewer tests and procedures. Nonetheless, the interaction of society-physician-patient inherent in the risk-shifting reimbursement schemes represents a definite albeit subtle shift of alliances, the outcome of which cannot be fully predicted, although it seems clear that all constraints on resources, by whatever device, will with time alter the perceptions and expectations of all the participants--about what is "owed" to whom, about what treatments are "appropriate" in what circumstances, and even about what qualifies as a "disease" for which medical attention is indicated. In effect, this would be an extension of a phenomenon observed some time ago by Freidson:

> As the state assumes more responsibility for the welfare of the layman, professionals become members of the class of caretakers, and the possibilities increase for differences between their perspective and that of laymen. Given the official status of the profession, what happens to the layman--that is, whether or not he will be recognized as "really" sick, what the sickness is called, what treatment will be given him, how he will be required to act when ill, and what will happen to him after treatment--becomes a function of professional rather than

> lay decision.... Furthermore, on an everyday basis [physicians] serve as gatekeepers to special resources (the most obvious of which are hospital beds and "ethical" drugs) that cannot be used without their permission. Thus, the behavior of the physician and others in the field of health constitutes the objectification, the empirical embodiment, of certain dominant values in a society (Freidson, 1970, p. 304).

Within these general confines, one can evaluate the ethical effects of the various risk-shifting proposals by differentiating those that involve greater risk (and hence generate greater pressure on the value of fidelity), those that affect the physician directly, and those that impose incentives/disincentives. In the first category, for example, DRG-based payments for conditions with a wide variation in treatment and outcome (such as many chronic mental illnesses) would be more problematic than for conditions in which the range of outcomes is predictably much smaller, so that the physician-as-insurer would be exposed to a smaller "downside" risk. In the second category, programs that place the risk on an organization, which employs the physician, are less likely to interfere with the physician's pursuit of the patients' interests than those which give the physician a greater financial role in managing the case and paying for the consultants, tests, and the like. Further, incentives and disincentives will probably prove more ethically problematic than explicit restrictions imposed by an institution or third-party payer on physicians' judgment because the incentives (and perhaps even the disincentives) would appeal to the physician to be complicit in achieving the institution's revenue-enhancing goals, while the explicit restrictions would be likely to generate resentment among medical professionals and therefore would be resisted (on the patient's behalf, one hopes).

Finally, physicians in plans that impose financial risks on them or others with whom they share economic interests may feel constrained not to inform patients of treatment alternatives not available within the plan or not covered by it when obtained elsewhere. To withhold such information would violate the norm of truth-telling that is part of the foundation of patients' trust in their physicians. Of course, a judgment about the possible appropriateness of care must be made by a physician--there is no obligation to mention treatments that offer minimal prospects, are in use only in limited research trials for which the patient is not eligible, or are otherwise inappropriate. But the judgment about appropriateness should not depend on the financial aspects of care, which are for the patient to decide. To the extent that certain limitations are built into the system, it is important that patients know about them so that they can employ the legitimate processes available to them, both within an individual treatment setting and through broader political processes, to seek to have such limitations changed.

From Increased Third-Party Supervision

As previously suggested, physicians' continued fidelity-to-patients' interests can be monitored if the review process is broadened to include fidelity/quality concerns, in addition to utilization review. Despite the importance of this objective, however, society has been slow to meet it. Notably, HCFA has only recently moved to establish the necessary criteria for peer review of the quality of HMO care, now that HMOs have been permitted since the beginning of 1985 to enroll Medicare beneficiaries under risk contracts with the Federal government (Wallace, 1985).

In addition to specially established review mechanisms, a number of traditional forms of review should also serve to deter laxity on the part of physicians in adhering to patients' interests. It must be remembered, however, that these safeguards--such as the tort system and procedures for the revocation of medical licenses when ethical violations demonstrate professional unsuitability--are designed primarily to discipline and deter deviant physicians. Since these processes are usually grounded on a norm of appropriate conduct articulated by the profession, they would do nothing to restrain conduct that departs from earlier views of a patient's best interests (e.g., how extensively to treat a dying cancer patient who develops renal failure) if that conduct accords with new norms of appropriate medical behavior. Such changes in norms occur for many reasons: new scientific findings, evolving cultural views about life, suffering and death, and--when the financing of health care becomes a matter of public concern, as it is today--changed social attitudes toward the extent that care should be provided under certain circumstances. Indeed, besides the slow evolution of professional norms (which would then be incoporated through expert testimony in malpractice cases or license-revocation proceedings), society may choose to give explicit sanction to actions taken by physicians to comply with the norms of review organizations, such as Professional Standard Review Organizations (Blumstein, 1981; Schuck, 1981).

Effects on Fairness Among Physicians From Limitations On Physicians' Financial Rewards

The effects of limitations on the financial rewards to physicians on inter-physician fairness will naturally depend on the nature of these limitations. Attempts to assert greater rationality in the fee system or to

increase the competition among physicians to provide services are likely to reduce the inequities created by the present fee-for-service system, which greatly overcompensates certain services and certain physicians. Changes that place physicians on fixed salaries (with only modest opportunities to earn "bonuses") will tend toward greater fairness to the extent that they reflect an open market for physicians services. Systems in which access to medical staff privileges are artifically constrained or in which practitioners in a particular field are unwilling to practice in pre-paid settings will be more subject to inequities among physicians. Even when markets operate freely, the lead time for speciality training will mean that the price paid physicians in various fields for their services may not reflect the "value" of those services in an ideal world.

From Physicians' Increased Exposure to Financial Risks

In systems in which illness-based or capitated payments go directly to physicians, those who provide services for illness with wider ranges of variation in severity and duration and those who treat patients with higher rates of complications are likely to suffer financially. Hence, increased exposure of physicians as individuals to financial risks are likely to give rise to increased unfairness. Such patterns of unfairness will not, however, follow the present patterns, which are largely based on specialties and their resulting predominance mix of procedures.

From Increased Third-Party Supervision

The greater emphasis on third-party review in all forms of cost-containment springs from the concern that the quality of patient care might otherwise decline. Third-party supervision of the appropriateness of care

would tend to improve fairness among physicians to the extent its purview includes disapproval of payment for unnecessary procedures (under fee-for-service), which now tend to lead to over-payment to certain specialties, and of unnecessary admissions or inappropriate diagnoses (under illness-based payment methods).

Effects on Access to Care

In some ways, the effects of various reimbursement methods on Medicare patients' access to health care ought to be a moot issue: if any segment of the American population can claim to be "guaranteed" health care as a matter of clearly articulated national policy, it is the over 65-year-old population. And yet experience with the program over the past 20 years plainly shows that the formulas used by Medicare to calculate physicians' reimbursement and the "payment slowdowns and snafus that have plagued the program" (McIlrath, 1985, p. 33) have led many physicians to refuse to participate in the program, effectively closing them off as sources of care for elderly patients. Moreover, the prospect of having to pay the difference between the reimbursement provided for a service by HCFA and the fee charged by a physician who does not accept Medicare assignment discourages some patients from seeking timely and appropriate care. Thus, it is apparent that the terms of any Medicare reimbursement program for physicians' services are capable of having a positive or a negative effect on the Medicare population's access to health care.

From Limitations on Physicians' Financial Rewards

As noted previously, all of the proposed changes in Medicare reimbursement methods are intended to limit physicians' financial rewards, but that effect

is more likely to be achieved by some of the proposals than by others. Several facts about reducing the costs of Part B (including cutting back on administrative costs, which delays the processing of claims) should be recognized: first, all such efforts are likely to have some negative effect on access to care, which is a serious ethical problem in light of the central moral significance of society's obligation to ensure access to an adequate level of care for all; further, annual program changes (such as have occurred in recent years as part of Congressional budget-balancing efforts) are particularly disruptive and thus likely to drive physicians out of the system; and finally, until reimbursement changes have had a chance to work their way through the system--which will require time for behavioral adjustments to be made by physicians and patients alike, including such matters as where, when, and from whom medical care is sought and is provided--alternative sources of care cannot be expected to arise to fill in the gaps in access created by the withdrawal of physicians who do not believe that Medicare rewards them sufficiently for their efforts. At the heart of the difficulty for Medicare patients is the fact that, although an important segment of the market, they are not the whole market; thus, changes in reimbursement rules that make them less attractive patients financially--especially changes that in relying on market-mechanisms actually serve to emphasize the competitive aspects of the provision, and obtaining, of health care today--will have an adverse effect on their ability to obtain care because the best medical resources will be drawn to other segments of the market where they will be more generously rewarded.

While all cost-controlling changes in reimbursement methods would thus be expected to affect access negatively (at least initially), programs featuring greater administrative simplicity (such as HMOs), special benefits to participating physicians (such as the access to a pool of enrolled patients

provided under a PPO agreement), and the smallest reductions in physicians' income and freedom to practice (such as refinements in current fee-for-service payment methods) would probably have the least negative (or the most positive) effects. Hypothetically, under the fee-for-service methods the adverse effects on physicians' net income exerted by lowered fees could result in increased access to care as physicians with "excess capacity" (i.e., time in their schedules) raised the number of interventions they initiated; this effect would occur, however, only to the extent that physicians sought out new patients, rather than simply doing more things to the same patients.

Moreover, stronger assignment requirements for physicians who wish to receive direct Medicare reimbursement for any patients, though perhaps a negative factor in the short run is likely to have a positive impact on access in the long run both because it actually simplifies physicians' activities and because it removes an impediment (actual or perceived) to some patients' obtaining health care.

From Physicians' Increased Exposure to Financial Risks

Some of the potentially most disturbing effects on patients' access to care could follow from reimbursement methods that shift some or all of the financial risks of treating patients from the insurance fund to physicians and/or institutions with which they are associated. As previously pointed out, physicians might get around price-lowering efforts by increasing the number of units; however, physicians (and health care institutions) can "beat" risk-shifting efforts only by attempting to exclude "high risk" patients from the pool of patients they will treat. Capitation programs, "packaging" of services, and prepaid arrangements such as HMOs have a built-in disincentive to accept the sickest and most needy patients, the very ones who have the hardest time obtaining health care.

Although the exclusion of Medicare patients from real access to the health care system is not likely to be a major problem under the proposals now being discussed in Congress, it must be recognized that greater rationing of services is not merely an unfortunate side-effect of these program but is rather their very intent, particularly of the programs that place some of the financial risks on the shoulders of physicians or the institutions in which they have employment or other interests. For some time now, the financial incentives provided by Medicare and other third-party payment systems simply reinforced physicians' professional norm of "do everything possible" for every patient. By shifting the incentives--and even creating the disincentive that comes from having one's own pocketbook at risk--the new methods of physician reimbursement would turn physicians into gatekeepers for the health care system whose decisions would no longer be based on medical criteria alone (i.e., "does my optimism lead me to think that medicine has something to offer this patient?") but would now have to take account of their own financial risk if they admit into the system patients whose care is going to cost more than Medicare is going to pay.

From Increased Third-Party Supervision

The effects of third-party supervision serve to illustrate the ways in which ethical values can clash with each other and not simply with pragmatic, economic considerations. As already suggested, it is likely that increased third-party review--like other administrative burdens--will have negative consequences for access to care because physicians do not like being "second-guessed" (which is more than a matter of pride, since reviewers' judgments may result in disallowance of claims submitted for Medicare reimbursement); nevertheless, as discussed above, third-party supervision that focuses on

fidelity/quality concerns is likely to be important--perhaps crucial--for ethical implementation of any new methods of reimbursement that produce new incentives for physicians.

EVALUATION OF PAYMENT ALTERNATIVES

Each of the possible alternatives for paying physicians for treating Medicare patients has ethical advantages and disadvantages. Comparing these advantages and disadvantages is at once very imprecise, because information is lacking from which the size of various effects can be accurately projected, and very subjective, because the positive or negative weight assigned to each effect will vary with the values of the evaluator. The author's assessment of the three major groupings of methods is as follows:

Fee-for-Service

All fee-for-service systems run the risk of rewarding overtreatment, which has generally been regarded as the principal source of conflict with the value of fidelity in medical care. The higher the fees and the greater the disparity of fees among types of services requiring equal effort (Williams, 1985), the greater this conflict. Thus, among fee systems, those that employ the market (PPOs) or an external set schedule are preferable to the present system or minor modifications in that system. Furthermore, the value of fairness among physicians would also seem to favor fee schedules (and perhaps PPOs), which would tend to eliminate unjustified difference among the payments made to providers for similar services.

The fee-for-service system creates ethical issues regarding access to care mostly to the extent that the level of fees or the way in which they are paid make Medicare beneficiaries financially unattractive patients, compared with

other patients; the risk of such limitations on access occurring is not merely hypothetical (witness the difficulty that Medicaid-paid patients have in finding appropriate nursing homes), but whether it would occur would depend upon the extent to which an oversupply of physicians would lead to competition for, rather than avoidance of, Medicare patients. As compared to other methods of reimbursement, fee-for-service may have less effect on access since it offers physicians the opportunity to keep up their total level of fees (and income) through greater intensity of services despite the lower fee-per-service; to the extent that utilization-review processes prevent this from occurring, the disincentive to treat Medicare patients woud be increased. (Of course, to the extent that one thinks that overtreatment--i.e., unjustified intensity of care--is a harm to patients, the effects of utilization (and quality) review on fidelity would be judged to be positive.)

Illness-Based Payment

Illness-based methods, such as payment for a package of services connected with a particular medical condition, go a long way to removing the incentive toward overtreatment. Of course, if made directly to physicians such payments contain a large element of financial risk and hence might induce undertreatment. Thus, those methods that spread the risk (by increasing the number of patients) and that remove the financial considerations from the bedside look more favorable from the viewpoint of fidelity to patients' interests. This is easier to accomplish for in-patient than for out-patient services, although a majority of physicians now practice in multi-specialty groups rather than alone. Likewise, by de-emphasizing the rewards of doing more procedures and by increasing physicians'incentives to act together, packaged-service payments made to an institution (such as the medical staff of

a hospital) increase fairness among physicians, assuming that a relatively free market exists within the institution through which physicians bargain for their salary or other methods of dividing the collective fees.

Paying for a package of services could have a negative impact on the access of some patients, namely those whose conditions are most complex and whose treatment is likely to require the greatest effort. Again, the more broadly such risks are spread, the less adverse such impact on access will be.

Capitation Payment

Of all methods, payment-per-enrollee presents the greatest incentive for appropriate use of resources because it discourages both overtreatment (which directly expends resources unnecessarily) and undertreatment (which risks later worsening of enrollees' health and hence avoidable expenses). Consequently, capitated payments, by creating a strong incentive for physicians to take an interest in their patients' health, serve the value of fidelity very well, provided that the element of financial risk to the individual provider is not too great. For example, in the case of a severe and prolonged illness that is likely to prove lethal, a provider would have a strong incentive to withhold life-prolonging treatment. In many cases this might be in the patient's "best interest" even when not specifically requested by the patient; but in reaching the judgment about "best interest," a provider who was personally at financial risk might be more inclined than a physician not at such risk to take a negative view of the value of continued treatment.

Of course, methods of external review can be helpful in avoiding such untoward effects. For example, reviewers could make sure that the decisions to write "do-not-resuscitate" (DNR) orders for patients were not always linked with termination of vigorous efforts to save the patients' lives. A decision

not to resuscitate does not signify that the results of continued treatment will not be favorable, provided that the patient's condition does not worsen to the point that resuscitation is needed. When a person at financial risk from continued treatment links a DNR order with discontinuation of treatment, suspicions are raised and questions need to be asked.

As with illness-based payment methods, capitated methods could decrease access of Medicare beneficiaries whose health is the poorest. Requirements that capitation-based programs (such as HMOs) take "all comers" in their geographic area would largely eliminate this access problem, however. This is an advantage over illness-based methods because it is easier to insist that a program enroll all eligible beneficiaries who wish to enroll than it is to insist that a physician or hospital accept as a patient any sick person who presents him or herself at the door.

ETHICS IN CHANGING TIMES

This report has attempted to elaborate the factors that ought to be evaluated if those responsible for designing and administering the Medicare system wish to take account of some of the major ethical--as well as the medical and economic--implications of new physician reimbursement methods. This chapter has explored a number (though certainly not all) of the expected consequences from the perspectives of medical and health care ethics; it has done so through a matrix of the major variables that characterize the plans and the major ethical parameters that seem relevant. Perhaps the greatest significance of the proposed changes in Medicare reimbursement lies not in the specifics of the alternatives but in certain factors that are common to all them all.

First, the plans signal a realization that medical expenditures must be contained, even at the cost of forgoing some potentially beneficial care. If the choices made in implementing these changes are going to be broadly acceptable, they will have to be based on a legitimate process that employs recognized ethical standards.

Second, to the extent that the plans all rely on some marketplace or economically driven behaviors, they reinforce a general trend away from viewing medicine as a special calling to viewing it as part of the marketplace itself. Again, this fact serves to underline the continuing importance of ethical precepts in protecting as much of the old norms of medicine as possible.

Finally, it must be recognized that the objectives of cost-containment programs must themselves be evaluated from an ethical perspective. If such efforts rest on an intention to reduce waste so that precious resources can be made available to persons who now lack adequate care, then the efforts themselves have ethical justification.

APPENDIX

VARIATIONS IN MEDICARE REIMBURSEMENT OF PHYSICIANS

The twelve-fold increase in national health expenditures between 1960 and 1983 owes much to the growth in the Medicare program, which in turn reflects the increasing proportion of elderly (especially the "old old," over 85 years-old) in the American population. It is thus not surprising that the national attention directed toward containing health care costs in the past decade has often focused on the Medicare program, which is not only faced with the risk of "bankruptcy" by 1995 if expenditures are not curtailed but whose actions are also frequently a model for other third-party payers. The Federal government, having taken steps in 1983 to rein-in hospital expenditures, is now addressing the physicians' portion of health care costs.

Existing Fee-for-Service System

Currently, Medicare payment of physicians is primarily on a fee-for-service basis. After the enrollee has paid an initial deductible of $75 per year, Medicare pays 80% of the "allowable charge," which is determined for each separately coded service by the customary, prevailing, and reasonable (CPR) method.1 Reliance on physician-set "customary" fees as the basis for the system has proven inflationary. Medicare Part B expenditures (three-fourths of which go for physician services) increased 20% a year from 1980 to 1983.2

Fees may vary by geographic location, physi- cian's specialty, type of visit, and site of ser- vice. As a result, the current system tends to favor urban/suburban, specialized, technological, hospital services, with the physician's hourly charge propor- tional to the resources controlled or

expended. (Jencks, Dobson, 1985). Little incentive is provided for efficient or economic treatment; instead, a physician has an incentive to select a particular treatment option for a Medicare patient from a range of medically acceptable procedures based on the relative rate of reimbursement. Furthermore, due to the complexity of the billing system, neither the patient or the physician is able to predict exactly what Medicare will cover. As a result, patients may be saddled with large unreimbursed charges as well.

Additionally, a physician may choose to accept or reject assignment of claims. If assignment is accepted, the physician bills Medicare directly, and Medicare's allowable charge is accepted as the service fee, thereby limiting the charge. In return, Medicare pays its share directly to the physician. If assignment is rejected, the physician must bill the patient. The physician is free to set the service fee independently, with the patient responsible for any part that exceeds Medicare's allowable charge.

Recent legislation (Medicare and Medicaid Budget Reconciliation Amendments of 1984, 2306, Public Law 98-369) allows the physician to accept assignment on a case-by-case basis or to accept assignment on all Medicare services, becoming a Medicare Participating Physician (MPP). Congress has provided several incentives to induce physicians to agree to become MPPs, including compiling and distributing MPP directories to senior groups, to social security offices, and (at a charge) to the public; establishing toll-free information lines for MPPs and beneficiaries; publicizing the MPP program; providing MPP emblems. The carrot of exemption from the current price freeze on physician services was also dangled before participating physicians (Medicare and Medicaid Guide, "Instructions," 1984), although continuing Federal budgetary problems may render this incentive illusory. Were such a plan to be implemented, MPPs would be allowed to submit bills for higher

amounts to update their customary charges, although the actual fee received would be based on the frozen CPR.

Alternative Fee-For-Service Methods

Refinement of Current Payment Methods

The least radical changes in Medicare reimbursement would involve modifying the current means of calculating the fee paid. For example, the current payment system could be changed by establishing a uniform fee for a given procedure. The fee could be standardized on the basis of the physician's specialty, the service site, the type of visit, the locality, or the region. Such a standardization would eliminate the inequality of payment for the same service in the same area, removing the "customary" factor from the equation.

Reimbursement could also be changed by altering assignment procedures. The option to reject assignment has been viewed as a license to overcharge.3 If Medicare made assignment mandatory, patients would be protected from these charges. However, mandatory assignment could result in several problems. Historically, a substantial number of physicians who were unwilling to be "participating physicians" nonetheless accepted assignment as payment in full for treating some of their patients. If these physicians continued to refuse to participate under a mandatory assignment program, they would become unavailable to patients who rely on Medicare payments for physicians' care. Thus, there might be a decrease in physician participation in the Medicare program and/or reduction in both access and quality of care; the result would be equal access to participating physicians instead of an assurance of equal access to all physicians with "reasonable charges" (Jencks, Dobson, 1985). It would also prevent patients' voluntary supplementation of Medicare rates in

order to obtain services from preferred, non-participating physicians. In order to obtain such services, a patient would have to assume full payment.

Another option would be to increase Medicare's percent payment on assigned claims, thereby guaranteeing a higher proportion of the fee to the physician. One way to fund the increased payment would be to discount payment on non-assigned claims (Hadley, 1984).4 A desirable side effect of this option would be to create an incentive for patients to seek care from physicians who accept assignment because the required co-payment would be lowered and uncovered costs would be avoided.

Periodic reassessment of the fees charged for procedures would also produce a change in payment. Typically, a new technology is introduced at a high price due to the specialized knowledge possessed by its developers and the limited supply of equipment to carry it out initially. As the procedures become routine, however, these costs begin to drop. The current system does not routinely monitor these declines and adjust the prices downward.

Limiting the fees charged by physicians for services provided outside of their practice would further change Medicare payment. Instead of allowing the physician to independently determine these charges, a set handling charge could be established, as has been done for laboratory tests on some specimens by Section 2303 of Public Law 98-369.

Payment could also be changed by modifying the method of calculating fee limits. This could be achieved in two ways. First, the rate at which physicians are paid could be changed by lowering the percentile of the allowable charge. Second, the method of calculating the economic index for annual increases could be changed.

Payment could also be controlled by requiring all services to be routed through a primary-care physician. Friedson (1970) has noted that an increasing number of people are circumventing the primary-care physician and dealing directly with the specialists. This has increased the cost of care in two ways. First, as noted earlier, the provision of specialty services itself generates higher bills. Second, the specialist has few incentives to provide cost-effective care.5 Requiring the primary-care physician to screen patients not only would reduce the greater cost of service for those not needing it, but would provide the opportunity for alternative, cheaper forms of treatment (e.g., patient education, non-surgical interventions).

Preferred Provider Organizations (PPOs)

PPOs are agreements between a payer and a group of physicians and other health care professionals who contract to provide medical services to a specific group of patients on the basis of negotiated (and generally discounted) fees. PPOs are primarily sponsored by hospitals and physician groups. Independent entrepreneurs and service purchasers (e.g., insurance companies, union and employee groups, and employers) also sponsor PPOs (Gabel, Ermann, 1985). A PPO provides incentives, such as lower co-payments or deductibles, for the patient to use participating providers, but still allows the patient to choose other providers. On the providers' side the incentives include access to a pool of patients and more rapid payment of bills. While services are provided at a discounted rate, thereby lowering the cost of individual treatment procedures, most PPOs provide no incentives to contain the number of services provided. Like other fee-for-service systems, a PPO provider's income rises with increased volume of services; the payer bears the major risk. PPOs are also vulnerable to charges of violating anti-trust laws6 and may be precluded by state laws.7

In adopting a PPO model, Medicare could use its economic clout to negotiate rates for services. Many of the incentives currently being utilized in the MPP program could be included to enhance the desirability of participation. For example, Medicare could pay a higher percent on PPO claims, to create greater incentives for patients to select PPOs. To avoid the problem of overtreatment, utilization review could be used to monitor the provision of services, evaluate provider performance, and deny payment for unnecessary treatment. If such denials failed to provide a sufficient detriment, Medicare could cancel or refuse to renew the PPO contract. Since such an action would result in a disruption in patient services and general confusion as to who is a PPO, Medicare might prefer to incorporate a fee cap to control overtreatment.

Explicit Fee Schedules

Explicit fee schedules could be constructed by HCFA to provide written information on the charge for medical interventions. All parties--Medicare, third party payers, the patient, and the physician--would then be aware of the cost of medical services in advance of actual patient use.

Fee schedules differ from refinements in current reimbursement methods because they are based on independent assessments of the value of a medical intervention rather than on mere variations in the existing pattern of charges. This could also have the effect of eliminating the wide range of charges for the same service in the same area (specialist versus generalist, urban versus rural) depending on how it was implemented.

To establish a fee schedule, it has been suggested that a "relative-value" scale be developed for all reimbursable medical procedures (Jencks, Dobson, 1985). It could be based on (a) all resource costs, (b) charges, (c)

physician time, and/or (d) consensus. All resource costs could include physician services, overhead, training expenses, etc. Charges could be based on prevailing area costs or could be standardized across the country. Physician time could be based on the time-cost of producing the service. It has been suggested that the degree of difficulty of the procedure should also be incorporated; however, this could lead to increased incentives to perform "difficult" procedures, resulting in increased costs (Jencks, Dobson, 1985). Consensus could be determined through competitive pricing (e.g., HMO costs, or bids), with the aim of finding the minimum prices at which physicians are willing to provide services. This would prevent access barriers, but would tend to maintain the current distribution of physicians and specialists.

All of these measures are actually based on comparison of input costs and might better be described as "relative-cost scales." The construction of an actual relative-value scale would require bases for measuring the medical value of various services in terms of outcome for patients--clearly a formidable task. The most likely process would involve the search for an expert consensus, akin to the Consensus Development Conferences sponsored by the National Institute of Health since 1975 (Mullan, Jacoby, 1985). A process involving only experts' views, however, would not necessarily reflect the true social consensus of informed consumers on the relative value of various outcomes (Pauly, 1979). The construction of relative values would be further complicated if separate values for a particular procedure were calculated for different diseases and conditions--i.e., the relative value of a CAT scan might differ when used for head injuries versus for recurrent headaches because the likelihood of improving patient outcome differs.

The monetary conversion factor, which would convert the relative values into fees, is critical. The exact multiplier is a political determination, but it must be set with care. If budgetary concerns (i.e., an attempt to hold down total Medicare spending) lead to too low a number, physicians may refuse to treat Medicare patients or reduce the quality of care. If it is too high, Medicare will increase reimbursement, resulting in excess delivery of less needed services (along with increasing physician income) (Hadley, 1984).

The relative-value scale system could be further strengthened by incorporating a utilization review process. Systematic review of the use of services could be used to control costs. Information could be fed back into both the relative value scale and the monetary conversion factor, resulting in appropriate adjustments. Thus, fee schedules are more likely to be successful in controlling costs than in ensuring that a particular level of use is targeted toward the most appropriate patients.

As with refinements in current payment mechanisms, the effectiveness of an explicit fee schedule in changing physicians' behavior and in controlling health care costs could be affected by changes in assignment rules and in the manner in which periodic adjustments in the fees are calculated. To prevent excess inflation, yearly increases could be limited by an economic index.

The relative-value scale could also form the basis of an indemnity (rather than an assignment) system. In such a system, the physician is not limited as to what can be billed; instead, the patient has an incentive to seek cheaper health care (Hadley, 1984). If payment were made on a voucher syble cost and the actual cost. By increasing the market-competitive aspects of selecting physicians and agreeing to procedures, indemnity and voucher systems would be expected to reduce physician fees.

Fee schedules which incorporate an expenditure ble cost and the actual cost. By increasing the market-competitive aspecap could also be developed. A total sum of money would be allocated for each service, using the relative-value scale as a guide. Physicians would then bill for services according to a fee schedule. However, as the physician's charges approached the fee cap, payment would be discounted (Glaser, 1978). In this way the incentives for overprovision of services would be eliminated. At the same time, however, access problems may arise when physicians who have met their "service quota" refuse to serve patients who need that service.

Fee schedules which incorporate controls on the rate at which services are provided could also be implemented. Methods that have been used include: (a) allowing a full fee for the most expensive service provided and a discounted fee (or no fee) for additional services performed at the same time; (b) decreasing fees over time for follow-up visits; (c) paying fees only in packages or bundles; (d) paying full fees for a service until it has been performed a certain number of times, and then discounting payment for subsequent performance (Glaser, 1970). Such schedules could also create problems of quality of care and access to services if certain procedures are discouraged due to low fees, or a disproportionate amount of physician time required.

Packaging of Services

The current Medicare coding system identifies 7,040 individual services which can be billed. Consequently, the physician is provided with incentives to bill for treatment on the basis of these individual activities rather than as a package or "bundle." This "unbundling" results in higher costs. Physicians are also given incentives to code procedures as if they were more

complex than they actually are--so-called "Code Creep"--resulting in higher costs (Jencks, Dobson, 1985).

Many types of packages could be developed to eliminate these practices. Office visit packages could be designed to combine physician and ancillary service costs. Diagnostic and therapeutic procedures could be combined in the same package as well. When treatment for the same problem is expected to extend over several visits, the package could be modified to cover this, reducing both costs and paperwork.

Billing packages could be designed to allow the physician to submit one bill for similar services for different patients (e.g., x-rays, blood tests, physical exams). This option could be combined with all defined office visit packages to allow single billing for multiple patients receiving similar packages of services.

Inpatient packages could be developed to cover all physician services for a particular hospitalization. More comprehensive packages could be developed to combine physician, ancillary, and hospital services. In order to prevent unnecessary hospital-based services, a "service window" could be incorporated to cover services before admission and after discharge (Jencks, Dobson, 1985). This would encourage the provision of services on an outpatient basis, as appropriate, and reduce the number of hospital days by removing the incentives to keep the patient hospitalized.

The combination of packaging physician services and prospective payment have been discussed as physician diagnosis-related groups (MDDRGs).8 MDDRGs would establish a single fee for all physician services provided during a given hospital stay. The MDDRG weights could be determined using a relative value scale, based on current allowable charges at the onset and later standardized nationally. The relative value scale could also be set on a

competitive basis. Jencks and Dobson (1985) have described three different payment methods for MDDRGs: paying the physician, paying the medical staff, and paying the hospital.

Paying the Physician

Medicare could pay the attending physician who would be responsible for paying all other consultants. This payment system could produce incentives to decrease the use of consultants and generally to reduce the provision of services to patients in order to reduce expenses and increase the attending physician's retained share of the fee. It would also result in disincentives to treat the seriously ill (who would require a greater amount of physician time). Additional potential side-effects include: increased administrative burdens, monitoring problems, and resentment by consultants. The physician could also attempt to shift costs by performing some services on an unbundled outpatient basis or using hospital services (e.g., ordering lab tests instead of a consult, using "free" hospital physicians instead of consultants).

Paying the Medical Staff

Medicare could credit the medical staff with Medicare's share of average allowable charges. The medical staff could pay its physicians at a rate which reflects the difference between the total MDDRG credits and the total allowable charges by the staff. If the charge exceeded the credit, the dollar value could be discounted; if it were less than the credit, the dollar value could be inflated. Alternatively, the medical staff could be given the MDDRG payments to distribute. The medical staff could also be subdivided to produce greater incentives to contain costs within each division. A small medical staff would be at financial risk of having too many "outliers" who are

expensive to treat; a patient pool needs to be sufficiently large to average out such statistical risks.

The medical staff would have the same incentives as the individual physician to avoid treating the seriously ill and, conversely, to increase admission of patients requiring little physician time. They would also be rewarded for admitting a patient twice for different procedures that could be performed in one visit. Additionally, unless the system were administered well, individual physicians would have few incentives to limit provision of services, since their income would increase with increased billing. Utilization review and group incentives could provide a method of curbing these costs.

Paying the Hospital

Medicare could pay the hospital both the hospital's DRG credits and the physician's MDDRG credits. The hospital could then allocate funds for certain physician services. Funds could be paid out through a medical staff model (as described above) or through a contract with the physicians. The hospital could contract to pay a base salary to physicians for performing routine medical duties and establish a fee schedule for non-routine services.9 Adjustments could be made based on specialty, experience, or seniority (years of Medicare service). Physician salary could further be manipulated by providing incentives based on number of cases seen, hours worked, profits generated, or revenue produced. Base salaries could be determined by negotiation or bid, and could be accompanied by a fringe benefit package. This system could also be applied to teaching hospitals, paying set amounts to academic physicians, hospital-based physicians, and residents. However, status conflicts and resentment of "salaried" physicians could occur in response to such a system.

Physician reimbursement could also be made based on a percentage of gross departmental charges. The gross receipts would be subject to adjustments for specified deductions, professional expenses, and unpaid bills. An alternative base would be a percentage of the net departmental income, subject to the above adjustments along with other internal costs. Physicians could also be paid according to a fee schedule or on a fee-for-service basis. Finally, the physician could negotiate a lease agreement with the hospital. The physician would then bill the patient, and pay the hospital for the use of equipment and space (Morrell, Rogan, 1978).

These hospital-based methods of compensation can be applied to the physician as an employee or as an independent contractor. Utilization review would provide a method for monitoring the provision of services. When the physician is a full time employee, hospital control of funds could result in decreasing the physician's role as patient advocate, undermining the independence of the medical staff and shifting the costs to an outpatient basis. Like the individual physician and the medical staff, the hospital has incentives to avoid the seriously ill. In fact, this system could lead to the creating of a "bounty" for profitable patients.

When the physician is an independent contractor either hospital-physician conflict or exploitation of the system by physicians may occur. On the one hand, if the physician is seen as an overprovider or not cost efficient, the hospital may respond by limiting access to some services, prescribing a two-tiered system of care (e.g., holding back services to DRG patients), or revoking hospital privileges. On the other hand, if the physician is closely tied to hospital goals, the physician may engage in questionable admission practices (e.g., multiple admissions for a single course of illness, admitting patients who could be served on an outpatient basis) to increase revenues (Morreim, 1985).

Capitation Payment

Adoption of an existing alternative practice arrangement has been proposed as a method of controlling Medicare costs. These arrangements vary in method of physician payment, financial risk, beneficiaries' freedom in selecting providers, and degree of incentives to monitor physician behavior.

Health Maintenance Organizations (HMOs)

HMOs are organizations which contract to provide services to patients based on a capitated fee. Enrollment, which defines the population served, is voluntary. The premium is not tied to actual use of services. Consequently, the HMO assumes part of the risk (Luft, 1981). The two most prevalent forms of HMOs are (a) independent practice associations (IPAs), and (b) prepaid group practices (PGPs) (Brown, 1983).

(a) IPAs are HMO health plans in which all or most of the health care costs are covered by prepaid premiums, even though the physician participants are paid on a fee-for-service basis (according to a discounted fee schedule). IPAs rarely own facilities; patients are seen in physicians' private offices and are sent to private clinics and hospitals. Generally, only a small amount of an IPA-participating physician's practice will consist of prepaid HMO patients. Although IPAs have the potential for effective utilization review and control--and can operate like PGPs--they generally operate like fee-for-service practice. Finally, if a patient leaves the IPA, the patient may continue to see the physician on a fee-for-service basis.

(b) PGPs are health plans that employ physicians (staff model) or contract with physician groups (group model) to provide health care services to enrollees in exchange for prepaid premiums. The physicians are generally salaried, and may be rewarded or penalized for their performance with respect to HMO targets (e.g., premium income or contract bid). Physicians work full time for the PGP and serve primarily the prepaid enrollees. The PGP generally owns its facilities, so the physician works in the plan's clinics and hospitals. Physicians in PGPs may make less money than fee-for-service providers, but are attracted by other benefits such as fixed schedules, guaranteed income and fringe benefits (e.g., malpractice insurance, retirement plans, sick days, time off and funds for continuing education), and fewer administrative burdens (Brown, 1983). However, loss of the physician's freedom to schedule and manage care, "bureaucratic" patients who demand care for trivial complaints, and lack of acceptance by community fee-for-service physicians have been identified as negative features of PGP practice (Brown, 1983).10

HMO income accrues from prepaid premiums. Consequently, HMOs are able to budget in advance of provision of services. Since total income is generally limited by premium payments, HMOs have no incentives to provide unnecessary or marginal care, and strong incentives to control costs. Costs can be controlled by utilization review of physicians, by limiting access to hospital beds and consultants, by the use of allied health professionals and by controlling enrollment. Studies of HMOs suggest that: (1) overall costs for care are 10-40% lower than conventional insurance (Luft, 1980); (2) hospitalization rates are up to 45% lower; (3) quality of care appears to be

as good as conventional insurance (Wolinsky, 1980). However, there appears to be no agreement on how these savings are achieved because of the diversity of the HMO programs themselves and the variety of factors that the studies have selected to evaluate.

On the one hand, HMO physicians are said to be better informed, more motivated, and regularly monitored; they lack the administrative and business distractions of private practice, and are free to concentrate on medicine (Brown, 1983). On the other hand, HMO policies can lead to underprovision of needed services, to increased caseloads, and to extensive queuing for services (Schneider, Stern, 1975). Physicians may be hesitant to recommend expensive lab tests and treatment procedures for fear that utilization reviews will identify them as "overproviders"--which could impact one's pay raises or yearly bonuses (Brown, 1983). Physicians may feel overworked when confronted with the increased caseloads necessary to make the HMO financially viable.11 If the physicians feel exploited, they may in turn provide impersonal, mechanical care. Ironically, the decreased amount of time spent with each patient could even result in physicians failing to detect conditions in their early stages (which directly conflicts with the goals of preventive medicine).

The demand for physician services also results in delays in obtaining services. While some queuing may be desirable, extended waits lead to failure to provide early intervention, and ultimately to more costly care. Queuing has also been used as a tool to encourage disenrollment in high risk patients (Brown, 1983). When needed care is hard to obtain, the patient is likely to seek it elsewhere. Advocates of HMOs insist that these problems are monitored and remedied by the peer review process. Methods of controlling queuing have included: charging extra for some services; requiring primary care physician referrals; use of physician's assistants and nurses to deliver care or screen

patients; requiring telephone consultations prior to granting an appointment; and simply telling members not to waste physician's time (Brown, 1983).

The HMO concept has been previously implemented on a large scale by a government body. In 1972 the California Health Department was allowed to contract with prepaid health plans to provide comprehensive health care to patients in Medi-Cal (the state's Medicaid program) (1972 Cal.Stat. 1366). Charges of fraud and abuse were first made in 1974. Practices such as consultant profiteering, coerced enrollment, some care provided in unaccredited and substandard hospitals, and failure of the state government to respond to these charges were made. (U.S. Congress, Senate, 1978).12 In order to gain more control, Congress passed the Health Maintenance Organization Amendments of 1976 (Public Law 94-96) which require all prepaid health plans receiving federal funds to be federally qualified. In September 1977 California responded with legislation directly addressing these problems (e.g., procedures for the control of fees charged, fraudulent claims, marketing and enrollment practices, provision of services (1977 Cal.Stat. 1036).

The California experience suggests the need for sufficient controls on HMO operations, along with an effective monitoring system, if HMOs are to be used successfully to provide services under publically financed programs. A monitoring system that includes quality as well as utilization review is especially important because HMOs bill only for premiums. In fee-for-service, the billing data already specify the services rendered from which a full judgment can be reached about the appropriateness of care.

Other Methods of Capitation

Different capitation rates could be established for patients on the basis

of age, sex, medical history, or institutional status. The rate for each group could be set according to the prevailing charge (locally or nationally), through negotiation, or through bidding. This amount could be paid either to a provider, as a monthly premium, or to the patient, as vouchers. This system could operate to provide comprehensive health care, like a prepaid health plan, or as a per patient financial account from which services are drawn.

Primary care could be provided on a capitated basis. The primary care physician would be paid a capitated rate for services provided. Any additional care would require a referral which could be paid on a fee-for-service, fee-schedule, or per-service basis. Alternately, separate capitation rates could be set for different types of inpatient and outpatient services.

A Social Health Maintenance Organization (S/HMO) has been suggested as a method of expanding the HMO concept to include long-term care (Diamond and Berman, 1981). S/HMOs would contract to provide a range of medical, social, and personal care services to a voluntarily enrolled population for a capitated fee. Selection of less expensive treatment alternatives, decreased institutionalization, and increased community and home-based care are anticipated. Due to the variety of services provided, S/HMOs can also be expected to contract for some services with existing providers. Additionally, the range of services provided, the organization, and the method of financing could also vary (Diamond and Berman, 1981). Congress has authorized the establishment of S/HMO demonstration sites (Medicare and Medicaid Budget Reconciliation Amendments of 1984, Public Law 98-369 2355), which will be under the direction of the University Health Policy Consortium, Brandeis University, and funded by the Health Care Financing Administration (Medicare and Medicaid Guide, New, 1984).

Finally, capitation could also be done regionally. Medicare could pay a capitated fee to an organization that would underwrite Medicare A & B for all patients in that area. The underwriter would be free to offer a variety of plans, but would be at risk. Therefore, the underwriter would have strong incentives for persuading patients to use the most efficient plans (Jencks, Dobson, 1985). Due to the number of patients involved the underwriter would also be provided with a great deal of economic clout with which to negotiate provider rates.

FOOTNOTES

1. When a physician submits a bill to Medicare, it is compared to two fee limits, the physician's customary fee for the service and the prevailing fee in the physician's geographic location. (The prevailing fee is subject to two fee screens, the 75th percentile of the area's customary charges, weighted by the number of times the service has been provided, and the Medicare economic index, which reflects the cost of doing business.) The reasonable charge is the lowest of the actual bill, the physician's customary charge, or the prevailing charges for the area. (Medicare and Medicaid Guide Dec, 1984).

2. Of the $51.1 billion Medicare spent in 1982, 71.9% was for hospital care, 22.3% was for physician services, .9% was for nursing home care, 4.9% was for "other health services." (U.S. DHHS, NCHS, 1984).

> National expenditures for physicians services have been rising over the past two decades at increasing rates, from 8.3 percent annually in the 1960-65 period to a 14.9 percent annual rate in 1980-82, despite a recession. These trends of rising expenditures have also been reflected in medicare program spending for physicians services, which increased 15.8 percent annually from 1970-75, 18.6 percent annually from 1975-80, and 20.9 percent per year over the 1980-82 period. Nevertheless, medicare's rate of increase has been significantly greater than national average trends--and the difference has been

widening. In the 1970-75 period, medicare spending for physicians services rose 4.1 percent per year faster than national spending; that difference increased to 5.2 percent per year in 1975-80 and 6 percent per year for 1980-82. (U.S. Congress, Senate, Special Committee on Aging).

3. Conversely, some physicians have viewed the option to reject assignment as a necessary means to avoid being locked into a payment structure that underpays them for some procedures.

4. To finance the reduction in cost-sharing for beneficiaries treated on assignment, Medicare could discount its payment for nonassigned claims. This would further increase the difference in beneficiary cost-sharing between assigned and nonassigned claims. Percentage reductions could be set so that the impact on taxpayers is neutral, with users of nonassigned services subsidizing reduced cost-sharing for users of assigned services.

Marginal changes in financial rewards and penalties would be much less disruptive than either the mandatory or all-or-none assignemnt proposals. Periodic adjustments could be made in percentage reductions in cost-sharing and fee amounts in order to meet assignment-rate goals. (Hadley, 1984)

5. The specialist is primarily colleague-dependent. Consequently, he/she does not have to compete in the patient market for clients and is less concerned with controlling costs. The primary care physician is primarily patient-dependent. As a result, if there is sufficient competition for clients, the primary-care physician may be more cost-conscious. See, Freidson (1970). But see, Robert Wood Johnson Foundation (1981) (More specialists appear to be providing primary care to patients. Additionally, the percentage of self-referrals by patients to specialists ranged from a low of 11.4% for neurosurgery to a high of 87.2% for pediatrics).

6. See Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332 (1982) (Maximum fee setting by physicians who were members of two medical foundations was a per se violation); Blue Shield v. McCready, 457 U.S. 465 (1982) (Patient may sue for an anti-trust violation when Blue Shield refused to reimburse for psychology services provided by a clinical psychologist rather than through a physician or by a psychiatrist). See generally, Blacker, (1984).

7. Nine states (California, Florida, Indiana, Louisiana, Michigan, Minnesota, Nebraska, Virginia, and Wisconsin) have enacted laws permitting prepaid health plans that potentially or actually limit choice of provider. Fifteen states have legislation pending. Congress also has legislation pending which would override state laws inhibiting these health plans (Gabel & Ermann, 1985).

8. MDDRGs would extend the Diagnosis-Related Groups (DRGs) system currently employed by Medicare for prospective payment of hospital services. DRGs are diagnostic related categories, grouped by body area into approximately 468 DRGs. The average price and weight of the procedure are multiplied to determine payment (Tichon, 1984).

9. If physicians try to obtain exclusive contracts with a hospital which is the sole funding source for the area, reduced access to individual physicians could result. Additionally, if a fierce bidding war ensued, quality of care could suffer as the physicians attempted to stay within their agreed-upon budget.

10. Potential fee-for-service physician responses to HMO physicians include: abusive phone calls and mail; denial of hospital privileges; cut-off of referrals; disappearance of patients' files; harassment at meetings (Brown, 1982).

11. Since the HMO physician's salary is fixed there are no incentives to work "overtime." In contrast the fee-for-service physician's income increases in direct proportion to the patient caseload. While the fee-for-service physician may view additional patients as a sign of confidence and an indication of desire for his/her personal services, the HMO physician is likely to feel exploited by the administratively increased caseload (Brown, 1982).

12. The report further describes marketing and enrollment abuse (e.g., commission-based, door-to-door solicitation in poor neighborhoods; enrollment signatures obtained through coercion or influence; forged enrollment signatures) and services problems (e.g., clinics closed on weekends and evenings with no arrangement for emergency treatment; incorrect medical records; lack of medical supervision in holding rooms; long delays in provision of treatment following diagnosis of ailments) (U.S. Congress,

Senate, 1978). See also Schneider and Stern (1975), which discusses skimming (refusing to sell to poor risks) and experience-rating (charging a higher premium for poor risks to limit enrollment).

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